

AMENDED IN ASSEMBLY JUNE 15, 2005

AMENDED IN SENATE APRIL 14, 2005

SENATE BILL

No. 375

Introduced by Senator Speier

February 17, 2005

An act to amend Sections 1358.4, 1358.5, 1358.6, 1358.8, 1358.9, 1358.10, 1358.11, 1358.14, 1358.15, *1358.16*, 1358.17, 1358.18, 1358.20, and 1358.21 of, and to repeal and add Section 1358.12 of, the Health and Safety Code, and to amend Sections 10192.4, 10192.5, 10192.6, 10192.8, 10192.9, 10192.10, 10192.11, 10192.14, 10192.15, 10192.17, 10192.18, 10192.20, and 10192.21 of, and to repeal and add Section 10192.12 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 375, as amended, Speier. Medicare supplement coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance. Under existing law, a plan or insurer that issues a Medicare supplement contract or policy, as defined, is required to comply with requirements in addition to those generally imposed on health care service plan contracts and health insurance policies.

This bill would make certain changes to these Medicare supplement coverage provisions corresponding to revisions made to the Medicare program by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The bill would revise eligibility requirements for Medicare supplement coverage, including the

guaranteed issue of coverage, and would add 2 benefit plans. The bill would also revise application procedures for this coverage.

Because a violation of the new requirements for Medicare supplement coverage issued by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1358.4 of the Health and Safety Code is
2 amended to read:
3 1358.4. The following definitions apply for the purposes of
4 this article:
5 (a) “Applicant” means:
6 (1) An individual enrollee who seeks to contract for health
7 coverage, in the case of an individual Medicare supplement
8 contract.
9 (2) An enrollee who seeks to obtain health coverage through a
10 group, in the case of a group Medicare supplement contract.
11 (b) “Bankruptcy” means that situation in which a Medicare
12 Advantage organization that is not an issuer has filed, or has had
13 filed against it, a petition for declaration of bankruptcy and has
14 ceased doing business in the state.
15 (c) “Continuous period of creditable coverage” means the
16 period during which an individual was covered by creditable
17 coverage, if during the period of the coverage the individual had
18 no breaks in coverage greater than 63 days.
19 (d) (1) “Creditable coverage” means, with respect to an
20 individual, coverage of the individual provided under any of the
21 following:
22 (A) Any individual or group contract, policy, certificate, or
23 program that is written or administered by a health care service
24 plan, health insurer, fraternal benefits society, self-insured

1 employer plan, or any other entity, in this state or elsewhere, and
2 that arranges or provides medical, hospital, and surgical coverage
3 not designed to supplement other private or governmental plans.
4 The term includes continuation or conversion coverage.

5 (B) Part A or B of Title XVIII of the federal Social Security
6 Act (Medicare).

7 (C) Title XIX of the federal Social Security Act (medicaid),
8 other than coverage consisting solely of benefits under Section
9 1928 of that act.

10 (D) Chapter 55 of Title 10 of the United States Code
11 (CHAMPUS).

12 (E) A medical care program of the Indian Health Service or of
13 a tribal organization.

14 (F) A state health benefits risk pool.

15 (G) A health plan offered under Chapter 89 of Title 5 of the
16 United States Code (Federal Employees Health Benefits
17 Program).

18 (H) A public health plan as defined in federal regulations
19 authorized by Section 2701(c)(1)(I) of the federal Public Health
20 Service Act, as amended by Public Law 104-191, the federal
21 Health Insurance Portability and Accountability Act of 1996.

22 (I) A health benefit plan under Section 5(e) of the federal
23 Peace Corps Act (Section 2504(e) of Title 22 of the United States
24 Code).

25 (J) Any other publicly sponsored program, provided in this
26 state or elsewhere, of medical, hospital, and surgical care.

27 (K) Any other creditable coverage as defined by subsection (c)
28 of Section 2701 of Title XXVII of the federal Public Health
29 Services Act (42 U.S.C. Sec. 300gg(c)).

30 (2) “Creditable coverage” shall not include one or more, or
31 any combination of, the following:

32 (A) Coverage for accident-only or disability income insurance,
33 or any combination thereof.

34 (B) Coverage issued as a supplement to liability insurance.

35 (C) Liability insurance, including general liability insurance
36 and automobile liability insurance.

37 (D) Workers’ compensation or similar insurance.

38 (E) Automobile medical payment insurance.

39 (F) Credit-only insurance.

40 (G) Coverage for onsite medical clinics.

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate, or contract or are otherwise not an integral part of the plan:

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits as are specified in federal regulations.

(4) “Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(5) “Creditable coverage” shall not include the following if offered as a separate policy, certificate, or contract:

(A) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act.

(B) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code.

(C) Similar supplemental coverage provided to coverage under a group health plan.

(e) “Employee welfare benefit plan” means a plan, fund, or program of employee benefits as defined in Section 1002 of Title 29 of the United States Code (Employee Retirement Income Security Act).

(f) “Insolvency” means when an issuer, licensed to transact the business of a health care service plan in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile.

(g) “Issuer” means a health care service plan delivering, or issuing for delivery, Medicare supplement contracts in this state, but does not include entities subject to Article 6 (commencing with Section 10192.1) of Chapter 1 of Division 2 of the Insurance Code.

(h) “Medicare” means the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

1 (i) “Medicare Advantage Plan” means a plan of coverage for
2 health benefits under Medicare Part C and includes:

3 (1) Coordinated care plans that provide health care services,
4 including, but not limited to, health care service plans (with or
5 without a point-of-service option), plans offered by
6 provider-sponsored organizations, and preferred provider
7 organizations plans.

8 (2) Medical savings account plans coupled with a contribution
9 into a Medicare Advantage medical savings account.

10 (3) Medicare Advantage private fee-for-service plans.

11 (j) “Medicare supplement contract” means a group or
12 individual plan contract of hospital and medical service
13 associations or health care service plans, other than a contract
14 issued pursuant to a contract under Section 1876 of the federal
15 Social Security Act (42 U.S.C.A. Section 1395mm) or an issued
16 contract under a demonstration project specified in Section
17 1395ss(g)(1) of Title 42 of the United States Code, that is
18 advertised, marketed, or designed primarily as a supplement to
19 reimbursements under Medicare for the hospital, medical, or
20 surgical expenses of persons eligible for Medicare. “Contract”
21 means “Medicare supplement contract,” unless the context
22 requires otherwise. “Medicare supplement contract” does not
23 include a Medicare Advantage plan established under Medicare
24 Part C, an outpatient prescription drug plan established under
25 Medicare Part D, or a health care prepayment plan that provides
26 benefits pursuant to an agreement under subparagraph (A) of
27 paragraph (1) of subsection (a) of Section 1833 of the Social
28 Security Act.

29 (k) “Secretary” means the Secretary of the United States
30 Department of Health and Human Services.

31 SEC. 2. Section 1358.5 of the Health and Safety Code is
32 amended to read:

33 1358.5. (a) A contract shall not be advertised, solicited, or
34 issued for delivery as a Medicare supplement contract unless the
35 contract contains definitions or terms that conform to the
36 requirements of this section.

37 (1) (A) “Accident,” “accidental injury,” or “accidental means”
38 shall be defined to employ “result” language and shall not
39 include words that establish an accidental means test or use

1 words such as “external, violent, visible wounds” or other similar
2 words of description or characterization.

3 (B) The definition shall not be more restrictive than the
4 following: “injury or injuries for which benefits are provided
5 means accidental bodily injury sustained by the covered person
6 that is the direct result of an accident, independent of disease or
7 bodily infirmity or any other cause, and occurs while coverage is
8 in force.”

9 (C) The definition may provide that injuries shall not include
10 injuries for which benefits are provided or available under any
11 workers’ compensation, employer’s liability, or similar law,
12 unless prohibited by law.

13 (2) “Benefit period” or “Medicare benefit period” shall not be
14 defined more restrictively than as defined in the Medicare
15 program.

16 (3) “Convalescent nursing home,” “extended care facility,” or
17 “skilled nursing facility” shall not be defined more restrictively
18 than as defined in the Medicare program.

19 (4) “Health care expenses” means for purposes of Section
20 1358.14, expenses of health care service plans associated with
21 the delivery of health care services, which expenses are
22 analogous to incurred losses of insurers.

23 (5) “Hospital” may be defined in relation to its status,
24 facilities, and available services or to reflect its accreditation by
25 the Joint Commission on Accreditation of Hospitals, but not
26 more restrictively than as defined in the Medicare Program.

27 (6) “Medicare” shall be defined in the contract. “Medicare”
28 may be substantially defined as “The Health Insurance for the
29 Aged Act, Title XVIII of the Social Security Amendments of
30 1965, as amended,” or “Title I, Part I of Public Law 89-97, as
31 enacted by the 89th Congress and popularly known as the Health
32 Insurance for the Aged Act, as amended,” or words of similar
33 import.

34 (7) “Medicare eligible expenses” shall mean expenses of the
35 kinds covered by Medicare Parts A and B, to the extent
36 recognized as reasonable and medically necessary by Medicare.

37 (8) “Physician” shall not be defined more restrictively than as
38 defined in the Medicare Program.

39 (9) (A) “Sickness” shall not be defined more restrictively than
40 as follows: “sickness means illness or disease of an insured

1 person that first manifests itself after the effective date of
2 insurance and while the insurance is in force.”

3 (B) The definition may be further modified to exclude
4 sicknesses or diseases for which benefits are provided under any
5 workers’ compensation, occupational disease, employer’s
6 liability, or similar law.

7 (b) Nothing in this section shall be construed as prohibiting
8 any contract, by definitions or express provisions, from limiting
9 or restricting any or all of the benefits provided under the
10 contract, except in-area and out-of-area emergency services, to
11 those health care services that are delivered by issuer, employed,
12 owned, or contracting providers, and provider facilities, so long
13 as the contract complies with the provisions of Sections 1358.14
14 and 1367 and with Section 1300.67 of Title 28 of the California
15 Code of Regulations.

16 (c) Nothing in this section shall be construed as prohibiting
17 any contract that limits or restricts any or all of the benefits
18 provided under the contract in the manner contemplated in
19 subdivision (b) from limiting its obligation to deliver services,
20 and disclaiming any liability from any delay or failure to provide
21 those services (1) in the event of a major disaster or epidemic or
22 (2) in the event of circumstances not reasonably within the
23 control of the issuer, such as the partial or total destruction of
24 facilities, war, riot, civil insurrection, disability of a significant
25 part of its health personnel, or similar circumstances so long as
26 the provisions comply with the provisions of subdivision (h) of
27 Section 1367.

28 SEC. 3. Section 1358.6 of the Health and Safety Code is
29 amended to read:

30 1358.6. (a) (1) Except for permitted preexisting condition
31 clauses as described in Sections 1358.7 and 1358.8, a contract
32 shall not be advertised, solicited, or issued for delivery as a
33 Medicare supplement contract if the contract contains definitions,
34 limitations, exclusions, conditions, reductions, or other
35 provisions that are more restrictive or limiting than that term as
36 officially used in Medicare, except as expressly authorized by
37 this article.

38 (2) No issuer may advertise, solicit, or issue for delivery any
39 Medicare supplement contract with hospital or medical coverage

1 if the contract contains any of the prohibited provisions described
2 in subdivision (b).

3 (b) The following provisions shall be deemed to be unfair,
4 unreasonable, and inconsistent with the objectives of this chapter
5 and shall not be contained in any Medicare supplement contract:

6 (1) Any waiver, exclusion, limitation, or reduction based on or
7 relating to a preexisting disease or physical condition, unless that
8 waiver, exclusion, limitation, or reduction (A) applies only to
9 coverage for specified services rendered not more than six
10 months from the effective date of coverage, (B) is based on or
11 relates only to a preexisting disease or physical condition defined
12 no more restrictively than a condition for which medical advice
13 was given or treatment was recommended by or received from a
14 physician within six months before the effective date of
15 coverage, (C) does not apply to any coverage under any group
16 contract, and (D) is approved in advance by the director. Any
17 limitations with respect to a preexisting condition shall appear as
18 a separate paragraph of the contract and be labeled "Preexisting
19 Condition Limitations."

20 (2) Except with respect to a group contract subject to, and in
21 compliance with, Section 1399.62, any provision denying
22 coverage, after termination of the contract, for services provided
23 continuously beginning while the contract was in effect, during
24 the continuous total disability of the subscriber or enrollee,
25 except that the coverage may be limited to a reasonable period of
26 time not less than the duration of the contract benefit period, if
27 any, and may be limited to the maximum benefits provided under
28 the contract.

29 (c) A Medicare supplement contract in force shall not contain
30 benefits that duplicate benefits provided by Medicare.

31 (d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of
32 Section 1358.8, a Medicare supplement contract with benefits for
33 outpatient prescription drugs that was issued prior to January 1,
34 2006, shall be renewed for current enrollees and subscribers, at
35 their option, who do not enroll in Medicare Part D.

36 (2) A Medicare supplement contract with benefits for
37 outpatient prescription drugs shall not be issued on and after
38 January 1, 2006.

39 (3) On and after January 1, 2006, a Medicare supplement
40 contract with benefits for outpatient prescription drugs shall not

1 be renewed after the enrollee or subscriber enrolls in Medicare
2 Part D unless both of the following conditions exist:

3 (A) The contract is modified to eliminate outpatient
4 prescription drug coverage for outpatient prescription drug
5 expenses incurred after the effective date of the individual's
6 coverage under a Medicare Part D plan.

7 (B) The premium is adjusted to reflect the elimination of
8 outpatient prescription drug coverage at the time of enrollment in
9 Medicare Part D, accounting for any claims paid if applicable.

10 SEC. 4. Section 1358.8 of the Health and Safety Code is
11 amended to read:

12 1358.8. The following standards are applicable to all
13 Medicare supplement contracts advertised, solicited, or issued for
14 delivery on or after January 1, 2001. A contract shall not be
15 advertised, solicited, or issued for delivery as a Medicare
16 supplement contract unless it complies with these benefit
17 standards.

18 (a) The following general standards apply to Medicare
19 supplement contracts and are in addition to all other requirements
20 of this article:

21 (1) A Medicare supplement contract shall not exclude or limit
22 benefits for losses incurred more than six months from the
23 effective date of coverage because it involved a preexisting
24 condition. The contract shall not define a preexisting condition
25 more restrictively than a condition for which medical advice was
26 given or treatment was recommended by or received from a
27 physician within six months before the effective date of
28 coverage.

29 (2) A Medicare supplement contract shall not indemnify
30 against losses resulting from sickness on a different basis than
31 losses resulting from accidents.

32 (3) A Medicare supplement contract shall provide that benefits
33 designed to cover cost-sharing amounts under Medicare will be
34 changed automatically to coincide with any changes in the
35 applicable Medicare deductible amount and copayment
36 percentage factors. Prepaid or periodic charges may be modified
37 to correspond with those changes.

38 (4) A Medicare supplement contract shall not provide for
39 termination of coverage of a spouse solely because of the
40 occurrence of an event specified for termination of coverage of

1 the covered person, other than the nonpayment of the prepaid or
2 periodic charge.

3 (5) Each Medicare supplement contract shall be guaranteed
4 renewable.

5 (A) The issuer shall not cancel or nonrenew the contract solely
6 on the ground of health status of the individual.

7 (B) The issuer shall not cancel or nonrenew the contract for
8 any reason other than nonpayment of the prepaid or periodic
9 charge or misrepresentation of the risk by the applicant that is
10 shown by the plan to be material to the acceptance for coverage.
11 The contestability period for Medicare supplement contracts shall
12 be two years.

13 (C) If a group Medicare supplement contract is terminated by
14 the subscriber and is not replaced as provided under
15 subparagraph (E), the issuer shall offer enrollees an individual
16 Medicare supplement contract that, at the option of the enrollee,
17 either provides for continuation of the benefits contained in the
18 terminated contract or provides for benefits that otherwise meet
19 the requirements of this subsection.

20 (D) If an individual is an enrollee in a group Medicare
21 supplement contract and the individual membership in the group
22 is terminated, the issuer shall either offer the enrollee the
23 conversion opportunity described in subparagraph (C) or, at the
24 option of the subscriber, shall offer the enrollee continuation of
25 coverage under the group contract.

26 (E) If a group Medicare supplement contract is replaced by
27 another group Medicare supplement contract purchased by the
28 same subscriber, the issuer of the replacement contract shall offer
29 coverage to all persons covered under the old group contract on
30 its date of termination. Coverage under the new contract shall not
31 result in any exclusion for preexisting conditions that would have
32 been covered under the group contract being replaced.

33 (F) If a Medicare supplement contract eliminates an outpatient
34 prescription drug benefit as a result of requirements imposed by
35 the Medicare Prescription Drug, Improvement, and
36 Modernization Act of 2003 (P.L. 108-173), the contract as
37 modified as a result of that act shall be deemed to satisfy the
38 guaranteed renewal requirements of this paragraph.

39 (6) Termination of a Medicare supplement contract shall be
40 without prejudice to any continuous loss that commenced while

the contract was in force, but the extension of benefits beyond the period during which the contract was in force may be predicated upon the continuous total disability of the covered person, limited to the duration of the contract benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(7) (A) (i) A Medicare supplement contract shall provide that benefits and prepaid or periodic charges under the contract shall be suspended at the request of the enrollee for the period, not to exceed 24 months, in which the enrollee has applied for and is determined to be entitled to medical assistance under Title XIX of the federal Social Security Act, but only if the enrollee notifies the issuer of the contract within 90 days after the date the individual becomes entitled to assistance.

If suspension occurs and if the enrollee loses entitlement to medical assistance, the contract shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the enrollee provides notice of loss of entitlement within 90 days after the date of loss and pays the prepaid or periodic charge attributable to the period, effective as of the date of termination of entitlement.

(ii) A Medicare supplement contract shall provide that benefits and premiums under the contract shall be suspended at the request of the enrollee or subscriber for any period that may be provided by federal regulation if the enrollee or subscriber is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and the enrollee or subscriber loses coverage under the group health plan, the contract shall be automatically reinstituted, effective as of the date of loss of coverage if the enrollee or subscriber provides notice within 90 days of the date of the loss of coverage.

(B) Reinstitution of coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement contract

1 provided coverage for outpatient prescription drugs, reinstitution
2 of the contract for a Medicare Part D enrollee shall not include
3 coverage for outpatient prescription drugs but shall otherwise
4 provide coverage that is substantially equivalent to the coverage
5 in effect before the date of suspension.

6 (iii) Shall provide for classification of prepaid or periodic
7 charges on terms at least as favorable to the enrollee as the
8 prepaid or periodic charge classification terms that would have
9 applied to the enrollee had the coverage not been suspended.

10 (8) A Medicare supplement contract shall not be limited to
11 coverage for a single disease or affliction.

12 (9) A Medicare supplement contract shall provide an
13 examination period of 30 days after the receipt of the contract by
14 the applicant for purposes of review, during which time the
15 applicant may return the contract as described in subdivision (e)
16 of Section 1358.17.

17 (10) A Medicare supplement contract shall additionally meet
18 any other minimum benefit standards as established by the
19 director.

20 (11) Within 30 days prior to the effective date of any Medicare
21 benefit changes, an issuer shall file with the director, and notify
22 its subscribers and enrollees of, modifications it has made to
23 Medicare supplement contracts.

24 (A) The notice shall include a description of revisions to the
25 Medicare Program and a description of each modification made
26 to the coverage provided under the Medicare supplement
27 contract.

28 (B) The notice shall inform each subscriber and enrollee as to
29 when any adjustment in the prepaid or periodic charges will be
30 made due to changes in Medicare benefits.

31 (C) The notice of benefit modifications and any adjustments to
32 the prepaid or periodic charges shall be in outline form and in
33 clear and simple terms so as to facilitate comprehension. The
34 notice shall not contain or be accompanied by any solicitation.

35 (12) No modifications to existing Medicare supplement
36 coverage shall be made at the time of, or in connection with, the
37 notice requirements of this article except to the extent necessary
38 to eliminate duplication of Medicare benefits and any
39 modifications necessary under the contract to provide indexed
40 benefit adjustment.

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a contract including only the following basic “core” package of benefits to each prospective applicant. This “core” package of benefits shall be referred to as standardized Medicare supplement benefit plan “A”. An issuer may make available to prospective applicants any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day to the 90th day, inclusive, in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the enrollee or subscriber for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient services, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(c) The following additional benefits shall be included in Medicare supplement benefit plans B to J, inclusive, only as provided by Section 1358.9.

(1) With respect to the Medicare Part A deductible, coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) With respect to skilled nursing facility care, coverage for the actual billed charges up to the coinsurance amount from the

1 21st day to the 100th day, inclusive, in a Medicare benefit period
2 for posthospital skilled nursing facility care eligible under
3 Medicare Part A.

4 (3) With respect to the Medicare Part B deductible, coverage
5 for all of the Medicare Part B deductible amount per calendar
6 year regardless of hospital confinement.

7 (4) With respect to 80 percent of the Medicare Part B excess
8 charges, coverage for 80 percent of the difference between the
9 actual Medicare Part B charge as billed, not to exceed any charge
10 limitation established by the Medicare Program or state law, and
11 the Medicare-approved Part B charge.

12 (5) With respect to 100 percent of the Medicare Part B excess
13 charges, coverage for all of the difference between the actual
14 Medicare Part B charge as billed, not to exceed any charge
15 limitation established by the Medicare Program or state law, and
16 the Medicare-approved Part B charge.

17 (6) With respect to the basic outpatient prescription drug
18 benefit, coverage for 50 percent of outpatient prescription drug
19 charges, after a two-hundred-fifty-dollar (\$250) calendar year
20 deductible, to a maximum of one thousand two hundred fifty
21 dollars (\$1,250) in benefits received by the insured per calendar
22 year, to the extent not covered by Medicare. On and after January
23 1, 2006, no Medicare supplement contract may be sold or issued
24 if it includes a prescription drug benefit.

25 (7) With respect to the extended outpatient prescription drug
26 benefit, coverage for 50 percent of outpatient prescription drug
27 charges, after a two-hundred-fifty-dollar (\$250) calendar year
28 deductible, to a maximum of three thousand dollars (\$3,000) in
29 benefits received by the insured per calendar year, to the extent
30 not covered by Medicare. On and after January 1, 2006, no
31 Medicare supplement contract may be sold or issued if it includes
32 a prescription drug benefit.

33 (8) With respect to medically necessary emergency care in a
34 foreign country, coverage to the extent not covered by Medicare
35 for 80 percent of the billed charges for Medicare-eligible
36 expenses for medically necessary emergency hospital, physician,
37 and medical care received in a foreign country, which care would
38 have been covered by Medicare if provided in the United States
39 and which care began during the first 60 consecutive days of
40 each trip outside the United States, subject to a calendar year

1 deductible of two hundred fifty dollars (\$250), and a lifetime
2 maximum benefit of fifty thousand dollars (\$50,000). For
3 purposes of this benefit, “emergency care” shall mean care
4 needed immediately because of an injury or an illness of sudden
5 and unexpected onset.

6 (9) With respect to the preventive medical care benefit,
7 coverage for the following preventive health services:

8 (A) An annual clinical preventive medical history and physical
9 examination that may include tests and services from
10 subparagraph (B) and patient education to address preventive
11 health care measures.

12 (B) The following screening tests or preventive services that
13 are not covered by Medicare, the selection and frequency of
14 which are determined to be medically appropriate by the
15 attending physician:

16 (i) Fecal occult blood test.

17 (ii) Mammogram.

18 (C) Influenza vaccine administered at any appropriate time
19 during the year.

20 Reimbursement shall be for the actual charges up to 100
21 percent of the Medicare-approved amount for each service, as if
22 Medicare were to cover the service as identified in American
23 Medical Association Current Procedural Terminology
24 (AMACPT) codes, to a maximum of one hundred twenty dollars
25 (\$120) annually under this benefit. This benefit shall not include
26 payment for any procedure covered by Medicare.

27 (10) With respect to the at-home recovery benefit, coverage
28 for services to provide short-term, at-home assistance with
29 activities of daily living for those recovering from an illness,
30 injury, or surgery.

31 (A) For purposes of this benefit, the following definitions shall
32 apply:

33 (i) “Activities of daily living” include, but are not limited to,
34 bathing, dressing, personal hygiene, transferring, eating,
35 ambulating, assistance with drugs that are normally
36 self-administered, and changing bandages or other dressings.

37 (ii) “Care provider” means a duly qualified or licensed home
38 health aide or homemaker, or a personal care aide or nurse
39 provided through a licensed home health care agency or referred
40 by a licensed referral agency or licensed nurses registry.

(iii) “Home” shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured’s place of residence.

(iv) “At-home recovery visit” means the period of a visit required to provide at-home recovery care, without any limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(B) With respect to coverage requirements and limitations, the following shall apply:

(i) At-home recovery services provided shall be primarily services that assist in activities of daily living.

(ii) The covered person’s attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to the following:

(I) No more than the number and type of at-home recovery visits certified as necessary by the covered person’s attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit.

(III) One thousand six hundred dollars (\$1,600) per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured’s home.

(VI) Services provided by a care provider as defined in subparagraph (A).

(VII) At-home recovery visits while the covered person is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the covered person is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(C) Coverage is excluded for the following:

1 (i) Home care visits paid for by Medicare or other government
2 programs.

3 (ii) Care provided by family members, unpaid volunteers, or
4 providers who are not care providers.

5 (d) The standardized Medicare supplement benefit plan “K”
6 shall consist of the following benefits:

7 (1) Coverage of 100 percent of the Medicare Part A hospital
8 coinsurance amount for each day used from the 61st to the 90th
9 day, inclusive, in any Medicare benefit period.

10 (2) Coverage of 100 percent of the Medicare Part A hospital
11 coinsurance amount for each Medicare lifetime inpatient reserve
12 day used from the 91st to the 150th day, inclusive, in any
13 Medicare benefit period.

14 (3) Upon exhaustion of the Medicare hospital inpatient
15 coverage, including the lifetime reserve days, coverage of 100
16 percent of the Medicare Part A eligible expenses for
17 hospitalization paid at the applicable prospective payment system
18 rate, or other appropriate Medicare standard of payment, subject
19 to a lifetime maximum benefit of an additional 365 days. The
20 provider shall accept the issuer’s payment for this benefit as
21 payment in full and shall not bill the enrollee or subscriber for
22 any balance.

23 (4) With respect to the Medicare Part A deductible, coverage
24 for 50 percent of the Medicare Part A inpatient hospital
25 deductible amount per benefit period until the out-of-pocket
26 limitation described in paragraph (10) is met.

27 (5) With respect to skilled nursing facility care, coverage for
28 50 percent of the coinsurance amount for each day used from the
29 21st day to the 100th day, inclusive, in a Medicare benefit period
30 for posthospital skilled nursing facility care eligible under
31 Medicare Part A until the out-of-pocket limitation described in
32 paragraph (10) is met.

33 (6) With respect to hospice care, coverage for 50 percent of
34 cost sharing for all Medicare Part A eligible expenses and respite
35 care until the out-of-pocket limitation described in paragraph
36 (10) is met.

37 (7) Coverage for 50 percent, under Medicare Part A or B, of
38 the reasonable cost of the first three pints of blood or equivalent
39 quantities of packed red blood cells, as defined under federal
40 regulations, unless replaced in accordance with federal

1 regulations, until the out-of-pocket limitation described in
2 paragraph (10) is met.

3 (8) Except for coverage provided in paragraph (9), coverage
4 for 50 percent of the cost sharing otherwise applicable under
5 Medicare Part B after the enrollee or subscriber pays the Part B
6 deductible, until the out-of-pocket limitation is met as described
7 in paragraph (10).

8 (9) Coverage of 100 percent of the cost sharing for Medicare
9 Part B preventive services, after the enrollee or subscriber pays
10 the Medicare Part B deductible.

11 (10) Coverage of 100 percent of all cost sharing under
12 Medicare Parts A and B for the balance of the calendar year after
13 the individual has reached the out-of-pocket limitation on annual
14 expenditures under Medicare Parts A and B of four thousand
15 dollars (\$4,000) in 2006, indexed each year by the appropriate
16 inflation adjustment specified by the secretary.

17 (e) The standardized Medicare supplement benefit plan “L”
18 shall consist of the following benefits:

19 (1) The benefits described in paragraphs (1), (2), (3), and (9)
20 of subdivision (d).

21 (2) With respect to the Medicare Part A deductible, coverage
22 for 75 percent of the Medicare Part A inpatient hospital
23 deductible amount per benefit period until the out-of-pocket
24 limitation described in paragraph (8) is met.

25 (3) With respect to skilled nursing facility care, coverage for
26 75 percent of the coinsurance amount for each day used from the
27 21st day to the 100th day, inclusive, in a Medicare benefit period
28 for posthospital skilled nursing facility care eligible under
29 Medicare Part A until the out-of-pocket limitation described in
30 paragraph (8) is met.

31 (4) With respect to hospice care, coverage for 75 percent of
32 cost sharing for all Medicare Part A eligible expenses and respite
33 care until the out-of-pocket limitation described in paragraph (8)
34 is met.

35 (5) Coverage for 75 percent, under Medicare Part A or B, of
36 the reasonable cost of the first three pints of blood or equivalent
37 quantities of packed red blood cells, as defined under federal
38 regulations, unless replaced in accordance with federal
39 regulations, until the out-of-pocket limitation described in
40 paragraph (8) is met.

(6) Except for coverage provided in paragraph (7), coverage for 75 percent of the cost sharing otherwise applicable under Medicare Part B after the enrollee or subscriber pays the Part B deductible until the out-of-pocket limitation described in paragraph (8) is met.

(7) Coverage for 100 percent of the cost sharing for Medicare Part B preventive services after the enrollee or subscriber pays the Part B deductible.

(8) Coverage of 100 percent of the cost sharing for Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of two thousand dollars (\$2,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(f) A contract shall not contain any provision delaying the effective date of coverage beyond the first day of the month following the date of receipt by the issuer of the applicant's properly completed application, except that the effective date of coverage may be delayed until the 65th birthday of an applicant who is to become eligible for Medicare by reason of age if the application is received any time during the three months immediately preceding the applicant's 65th birthday.

SEC. 5. Section 1358.9 of the Health and Safety Code is amended to read:

1358.9. (a) An issuer shall make available to each prospective enrollee a contract form containing only the basic (core) benefits, as defined in subdivision (b) of Section 1358.8.

(b) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted by subdivision (f) and by Section 1358.10.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A to J, inclusive, listed in subdivision (e), and shall conform to the definitions in Section 1358.4. Each benefit shall be structured in accordance with the format provided in subdivisions (b), (c), (d), and (e) of Section 1358.8 and list the benefits in the order listed in subdivision (e). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

1 (d) An issuer may use, in addition to the benefit plan
2 designations required in subdivision (c), other designations to the
3 extent permitted by law.

4 (e) With respect to the makeup of benefit plans, the following
5 shall apply:

6 (1) Standardized Medicare supplement benefit plan A shall be
7 limited to the basic (core) benefit common to all benefit plans, as
8 defined in subdivision (b) of Section 1358.8.

9 (2) Standardized Medicare supplement benefit plan B shall
10 include only the following: the core benefit, plus the Medicare
11 Part A deductible as defined in paragraph (1) of subdivision (c)
12 of Section 1358.8.

13 (3) Standardized Medicare supplement benefit plan C shall
14 include only the following: the core benefit, plus the Medicare
15 Part A deductible, skilled nursing facility care, Medicare Part B
16 deductible, and medically necessary emergency care in a foreign
17 country as defined in paragraphs (1), (2), (3), and (8) of
18 subdivision (c) of Section 1358.8, respectively.

19 (4) Standardized Medicare supplement benefit plan D shall
20 include only the following: the core benefit, plus the Medicare
21 Part A deductible, skilled nursing facility care, medically
22 necessary emergency care in a foreign country, and the at-home
23 recovery benefit as defined in paragraphs (1), (2), (8), and (10) of
24 subdivision (c) of Section 1358.8, respectively.

25 (5) Standardized Medicare supplement benefit plan E shall
26 include only the following: the core benefit, plus the Medicare
27 Part A deductible, skilled nursing facility care, medically
28 necessary emergency care in a foreign country, and preventive
29 medical care as defined in paragraphs (1), (2), (8), and (9) of
30 subdivision (c) of Section 1358.8, respectively.

31 (6) Standardized Medicare supplement benefit plan F shall
32 include only the following: the core benefit, plus the Medicare
33 Part A deductible, the skilled nursing facility care, the Medicare
34 Part B deductible, 100 percent of the Medicare Part B excess
35 charges, and medically necessary emergency care in a foreign
36 country as defined in paragraphs (1), (2), (3), (5), and (8) of
37 subdivision (c) of Section 1358.8, respectively.

38 (7) Standardized Medicare supplement benefit high deductible
39 plan F shall include only the following: 100 percent of covered
40 expenses following the payment of the annual high deductible

1 plan F deductible. The covered expenses include the core benefit,
2 plus the Medicare Part A deductible, skilled nursing facility care,
3 the Medicare Part B deductible, 100 percent of the Medicare Part
4 B excess charges, and medically necessary emergency care in a
5 foreign country as defined in paragraphs (1), (2), (3), (5), and (8)
6 of subdivision (c) of Section 1358.8, respectively. The annual
7 high deductible plan F deductible shall consist of out-of-pocket
8 expenses, other than premiums, for services covered by the
9 Medicare supplement plan F policy, and shall be in addition to
10 any other specific benefit deductibles. The annual high
11 deductible Plan F deductible shall be one thousand five hundred
12 dollars (\$1,500) for 1998 and 1999, and shall be based on the
13 calendar year, as adjusted annually thereafter by the secretary to
14 reflect the change in the Consumer Price Index for all urban
15 consumers for the 12-month period ending with August of the
16 preceding year, and rounded to the nearest multiple of ten dollars
17 (\$10).

18 (8) Standardized Medicare supplement benefit plan G shall
19 include only the following: the core benefit, plus the Medicare
20 Part A deductible, skilled nursing facility care, 80 percent of the
21 Medicare Part B excess charges, medically necessary emergency
22 care in a foreign country, and the at-home recovery benefit as
23 defined in paragraphs (1), (2), (4), (8), and (10) of Section
24 1358.8, respectively.

25 (9) Standardized Medicare supplement benefit plan H shall
26 consist of only the following: the core benefit, plus the Medicare
27 Part A deductible, skilled nursing facility care, basic outpatient
28 prescription drug benefit, and medically necessary emergency
29 care in a foreign country as defined in paragraphs (1), (2), (6),
30 and (8) of Section 1358.8, respectively. The outpatient
31 prescription drug benefit shall not be included in a Medicare
32 supplement contract sold on or after January 1, 2006.

33 (10) Standardized Medicare supplement benefit plan I shall
34 consist of only the following: the core benefit, plus the Medicare
35 Part A deductible, skilled nursing facility care, 100 percent of the
36 Medicare Part B excess charges, basic outpatient prescription
37 drug benefit, medically necessary emergency care in a foreign
38 country, and at-home recovery benefit as defined in paragraphs
39 (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section
40 1358.8, respectively. The outpatient prescription drug benefit

1 shall not be included in a Medicare supplement contract sold on
2 or after January 1, 2006.

3 (11) Standardized Medicare supplement benefit plan J shall
4 consist of only the following: the core benefit, plus the Medicare
5 Part A deductible, skilled nursing facility care, Medicare Part B
6 deductible, 100 percent of the Medicare Part B excess charges,
7 extended outpatient prescription drug benefit, medically
8 necessary emergency care in a foreign country, preventive
9 medical care, and at-home recovery benefit as defined in
10 paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision
11 (c) of Section 1358.8, respectively. The outpatient prescription
12 drug benefit shall not be included in a Medicare supplement
13 contract sold on or after January 1, 2006.

14 (12) Standardized Medicare supplement benefit high
15 deductible plan J shall consist of only the following: 100 percent
16 of covered expenses following the payment of the annual high
17 deductible plan J deductible. The covered expenses include the
18 core benefit, plus the Medicare Part A deductible, skilled nursing
19 facility care, Medicare Part B deductible, 100 percent of the
20 Medicare Part B excess charges, extended outpatient prescription
21 drug benefit, medically necessary emergency care in a foreign
22 country, preventive medical care benefit, and at-home recovery
23 benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and
24 (10) of subdivision (c) of Section 1358.8, respectively. The
25 annual high deductible plan J deductible shall consist of
26 out-of-pocket expenses, other than premiums, for services
27 covered by the Medicare supplement plan J policy, and shall be
28 in addition to any other specific benefit deductibles. The annual
29 deductible shall be one thousand five hundred dollars (\$1,500)
30 for 1998 and 1999, and shall be based on a calendar year, as
31 adjusted annually thereafter by the secretary to reflect the change
32 in the Consumer Price Index for all urban consumers for the
33 12-month period ending with August of the preceding year, and
34 rounded to the nearest multiple of ten dollars (\$10). The
35 outpatient prescription drug benefit shall not be included in a
36 Medicare supplement contract sold on or after January 1, 2006.

37 (13) Standardized Medicare supplement benefit plan K shall
38 consist of only those benefits described in subdivision (d) of
39 Section 1358.8.

1 (14) Standardized Medicare supplement benefit plan L shall
2 consist of only those benefits described in subdivision (e) of
3 Section 1358.8.

4 (f) An issuer may, with the prior approval of the director, offer
5 contracts with new or innovative benefits in addition to the
6 benefits provided in a contract that otherwise complies with the
7 applicable standards. The new or innovative benefits may include
8 benefits that are appropriate to Medicare supplement contracts,
9 that are not otherwise available and that are cost-effective and
10 offered in a manner that is consistent with the goal of
11 simplification of Medicare supplement contracts. On and after
12 January 1, 2006, the innovative benefit shall not include an
13 outpatient prescription drug benefit.

14 SEC. 6. Section 1358.10 of the Health and Safety Code is
15 amended to read:

16 1358.10. (a) (1) This section shall apply to Medicare Select
17 contracts, as defined in this section.

18 (2) A contract shall not be advertised as a Medicare Select
19 contract unless it meets the requirements of this section.

20 (b) For the purposes of this section:

21 (1) "Complaint" means any dissatisfaction expressed by an
22 individual concerning a Medicare Select issuer or its network
23 providers.

24 (2) "Grievance" means dissatisfaction expressed in writing by
25 an individual covered by a Medicare Select contract with the
26 administration, claims practices, or provision of services
27 concerning a Medicare Select issuer or its network providers.

28 (3) "Medicare Select issuer" means an issuer offering, or
29 seeking to offer, a Medicare Select contract.

30 (4) "Medicare Select contract" means a Medicare supplement
31 contract that contains restricted network provisions.

32 (5) "Network provider" means a provider of health care, or a
33 group of providers of health care, which has entered into a
34 written agreement with the issuer to provide benefits covered
35 under a Medicare Select contract. "Provider network" means a
36 grouping of network providers.

37 (6) "Restricted network provision" means any provision which
38 conditions the payment of benefits, in whole or in part, on the use
39 of network providers.

(7) “Service area” means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select contract.

(c) The director may authorize an issuer to offer a Medicare Select contract pursuant to Section 4358 of the federal Omnibus Budget Reconciliation Act (OBRA) of 1990 if the director finds that the issuer’s Medicare Select contracts are in compliance with this chapter and if the director finds that the issuer has satisfied all of the requirements of this section.

(d) A Medicare Select issuer shall not issue a Medicare Select contract in this state until its plan of operation has been approved by the director.

(e) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of all of the following:

(A) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and afterhour care. The hours of operation and availability of afterhour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) That the number of network providers in the service area is sufficient, with respect to current and expected enrollees, as to either of the following:

(i) To deliver adequately all services that are subject to a restricted network provision.

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 24 hours per day and seven days per week.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, that there are written agreements with network providers prohibiting the providers from billing or otherwise seeking

1 reimbursement from or recourse against any individual covered
2 under a Medicare Select contract.

3 This subparagraph shall not apply to supplemental charges or
4 coinsurance amounts as stated in the Medicare Select contract.

5 (2) A statement or map providing a clear description of the
6 service area.

7 (3) A description of the grievance procedure to be utilized.

8 (4) A description of the quality assurance program, including
9 all of the following:

10 (A) The formal organizational structure.

11 (B) The written criteria for selection, retention, and removal of
12 network providers.

13 (C) The procedures for evaluating quality of care provided by
14 network providers, and the process to initiate corrective action
15 when warranted.

16 (5) A list and description, by specialty, of the network
17 providers.

18 (6) Copies of the written information proposed to be used by
19 the issuer to comply with subdivision (i).

20 (7) Any other information requested by the director.

21 (f) (1) A Medicare Select issuer shall file any proposed
22 changes to the plan of operation, except for changes to the list of
23 network providers, with the director prior to implementing the
24 changes. Changes shall be considered approved by the director
25 after 30 days unless specifically disapproved.

26 (2) An updated list of network providers shall be filed with the
27 director at least quarterly.

28 (g) A Medicare Select contract shall not restrict payment for
29 covered services provided by nonnetwork providers if:

30 (1) The services are for symptoms requiring emergency care
31 or are immediately required for an unforeseen illness, injury, or
32 condition.

33 (2) It is not reasonable to obtain services through a network
34 provider.

35 (h) A Medicare Select contract shall provide payment for full
36 coverage under the contract for covered services that are not
37 available through network providers.

38 (i) A Medicare Select issuer shall make full and fair disclosure
39 in writing of the provisions, restrictions, and limitations of the

1 Medicare Select contract to each applicant. This disclosure shall
2 include at least the following:

3 (1) An outline of coverage sufficient to permit the applicant to
4 compare the coverage and charges of the Medicare Select
5 contract with both of the following:

6 (A) Other Medicare supplement contracts offered by the
7 issuer.

8 (B) Other Medicare Select contracts.

9 (2) A description, including address, telephone number, and
10 hours of operation, of the network providers, including primary
11 care physicians, specialty physicians, hospitals, and other
12 providers.

13 (3) A description of the restricted network provisions,
14 including payments for coinsurance and deductibles when
15 providers other than network providers are utilized. The
16 description shall inform the applicant that expenses incurred
17 when using out-of-network providers are excluded from the
18 out-of-pocket annual limit in benefit plans K and L, unless the
19 contract provides otherwise.

20 (4) A description of coverage for emergency and urgently
21 needed care and other out-of-service area coverage.

22 (5) A description of limitations on referrals to restricted
23 network providers and to other providers.

24 (6) A description of the enrollee's rights to purchase any other
25 Medicare supplement contract otherwise offered by the issuer.

26 (7) A description of the Medicare Select issuer's quality
27 assurance program and grievance procedure.

28 (j) Prior to the sale of a Medicare Select contract, a Medicare
29 Select issuer shall obtain from the applicant a signed and dated
30 form stating that the applicant has received the information
31 provided pursuant to subdivision (i) and that the applicant
32 understands the restrictions of the Medicare Select contract.

33 (k) A Medicare Select issuer shall have and use procedures for
34 hearing complaints and resolving written grievances from the
35 enrollees. The procedures shall be aimed at mutual agreement for
36 settlement and may include arbitration procedures.

37 (1) The grievance procedure shall be described in the contract
38 and in the outline of coverage.

1 (2) At the time the contract is issued, the issuer shall provide
2 detailed information to the enrollee describing how a grievance
3 may be registered with the issuer.

4 (3) Grievances shall be considered in a timely manner and
5 shall be transmitted to appropriate decisionmakers who have
6 authority to fully investigate the issue and take corrective action.

7 (4) If a grievance is found to be valid, corrective action shall
8 be taken promptly.

9 (5) All concerned parties shall be notified about the results of
10 a grievance.

11 (6) The issuer shall report no later than each March 31st to the
12 director regarding its grievance procedure. The report shall be in
13 a format prescribed by the director and shall contain the number
14 of grievances filed in the past year and a summary of the subject,
15 nature, and resolution of those grievances.

16 (l) At the time of initial purchase, a Medicare Select issuer
17 shall make available to each applicant for a Medicare Select
18 contract the opportunity to purchase any Medicare supplement
19 contract otherwise offered by the issuer.

20 (m) (1) At the request of an enrollee under a Medicare Select
21 contract, a Medicare Select issuer shall make available to the
22 enrollee the opportunity to purchase a Medicare supplement
23 contract offered by the issuer that has comparable or lesser
24 benefits and that does not contain a restricted network provision,
25 if a Medicare supplement contract of that nature is offered by the
26 issuer. The issuer shall make the contracts available without
27 regard to the health status of the enrollee and without requiring
28 evidence of insurability after the Medicare Select contract has
29 been in force for six months.

30 (2) For the purposes of this subdivision, a Medicare
31 supplement contract will be considered to have comparable or
32 lesser benefits unless it contains one or more significant benefits
33 not included in the Medicare Select contract being replaced. For
34 the purposes of this paragraph, a significant benefit means
35 coverage for the Medicare Part A deductible, coverage for
36 at-home recovery services, or coverage for Medicare Part B
37 excess charges.

38 (n) Medicare Select contracts shall provide for continuation of
39 coverage in the event the secretary determines that Medicare
40 Select contracts issued pursuant to this section should be

1 discontinued due to either the failure of the Medicare Select
2 program to be reauthorized under law or its substantial
3 amendment.

4 (1) Each Medicare Select issuer shall make available to each
5 enrollee covered by a Medicare Select contract the opportunity to
6 purchase any Medicare supplement contract offered by the issuer
7 that has comparable or lesser benefits and that does not contain a
8 restricted provider network provision, if a Medicare supplement
9 contract of that nature is offered by the issuer. The issuer shall
10 make the contracts available without regard to the health status of
11 the enrollee and without requiring evidence of insurability after
12 the Medicare Select contract has been in force for six months.

13 (2) For the purposes of this subdivision, a Medicare
14 supplement contract will be considered to have comparable or
15 lesser benefits unless it contains one or more significant benefits
16 not included in the Medicare Select contract being replaced. For
17 the purposes of this paragraph, a significant benefit means
18 coverage for the Medicare Part A deductible, coverage for
19 at-home recovery services, or coverage for Medicare Part B
20 excess charges.

21 (o) An issuer offering Medicare Select contracts shall comply
22 with reasonable requests for data made by state or federal
23 agencies, including the United States Department of Health and
24 Human Services, for the purpose of evaluating the Medicare
25 Select program. An issuer shall not issue a Medicare Select
26 contract in this state until the contract has been approved by the
27 director.

28 SEC. 7. Section 1358.11 of the Health and Safety Code is
29 amended to read:

30 1358.11. (a) (1) An issuer shall not deny or condition the
31 offering or effectiveness of any Medicare supplement contract
32 available for sale in this state, nor discriminate in the pricing of a
33 contract because of the health status, claims experience, receipt
34 of health care, or medical condition of an applicant in the case of
35 an application for a contract that is submitted prior to or during
36 the six-month period beginning with the first day of the first
37 month in which an individual *is both 65 years of age or older*
38 *and* is enrolled for benefits under Medicare Part B. Each
39 Medicare supplement contract currently available from an issuer

shall be made available to all applicants who qualify under this subdivision *and who are 65 years of age or older.* ~~This~~

(2) *An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants, Medicare supplement benefit plan H, I, or J, if currently available, and commencing January 1, 2007, shall make available to them Medicare supplement benefit plan K or L, if currently available. The selection among Medicare supplement benefit plan H, I, or J and the selection between Medicare supplement benefit plan K or L shall be made at the issuer's discretion.*

(3) *This section and Section 1358.12 do not prohibit an issuer in determining subscriber rates from treating applicants who are under 65 years of age and are eligible for Medicare Part B as a separate risk classification.*

(b) (1) *If an applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.*

(2) *If the applicant qualifies under subdivision (a) and submits an application during the time period referenced in subdivision (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The manner of the reduction under this subdivision shall be as specified by the director.*

(c) *Except as provided in subdivision (b) and Section 1358.23, subdivision (a) shall not be construed as preventing the exclusion of benefits under a contract, during the first six months, based on a preexisting condition for which the enrollee received treatment or was otherwise diagnosed during the six months before the coverage became effective.*

1 (d) Sales during the open enrollment period shall not be
2 discouraged by any means, including the altering of the
3 commission structure.

4 (e) (1) An individual enrolled in Medicare Part B is entitled to
5 open enrollment described in this section for six months
6 following:

7 (A) Receipt of a notice of termination or, if no notice is
8 received, the effective date of termination from any
9 employer-sponsored health plan including an
10 employer-sponsored retiree health plan.

11 (B) Receipt of a notice of loss of eligibility due to the divorce
12 or death of a spouse or, if no notice is received, the effective date
13 of loss of eligibility due to the divorce or death of a spouse, from
14 any employer-sponsored health plan including an
15 employer-sponsored retiree health plan.

16 (C) Termination of health care services for a military retiree or
17 the retiree's Medicare eligible spouse or dependent as a result of
18 a military base closure or loss of access to health care services
19 because the base no longer offers services or because the
20 individual relocates.

21 (2) For purposes of this subdivision, "employer-sponsored
22 retiree health plan" includes any coverage for medical expenses
23 that is directly or indirectly sponsored or established by an
24 employer for employees or retirees, their spouses, dependents, or
25 other included covered persons.

26 (f) An individual enrolled in Medicare Part B is entitled to
27 open enrollment described in this section if the individual was
28 covered under a policy, certificate, or contract providing
29 Medicare supplement coverage but that coverage terminated
30 because the individual established residence at a location not
31 served by the issuer.

32 (g) (1) An individual whose coverage was terminated by a
33 Medicare Advantage plan shall be entitled to an additional
34 60-day open enrollment period to be added on to and run
35 consecutively after any open enrollment period authorized by
36 federal law or regulation, for any and all Medicare supplement
37 coverage available on a guaranteed basis under state and federal
38 law or regulations for persons terminated by their Medicare
39 Advantage plan.

(2) Health plans that terminate Medicare enrollees shall notify those enrollees in the termination notice of the additional open enrollment period authorized by this subdivision. Health plan notices shall inform enrollees of the opportunity to secure advice and assistance from the HICAP in their area, along with the toll-free telephone number for HICAP.

(h) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no issuer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy, certificate, or contract. An issuer that offers Medicare supplement contracts shall notify an enrollee of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

(i) ~~An~~ *Commencing January 1, 2007*, an individual enrolled in Medicare Part B is entitled to open enrollment described in this section upon being notified that he or she is no longer eligible for benefits under the Medi-Cal program *because of an increase in the individual's income or assets*.

SEC. 8. Section 1358.12 of the Health and Safety Code is repealed.

SEC. 9. Section 1358.12 is added to the Health and Safety Code, to read:

1358.12. (a) (1) With respect to the guaranteed issue of a Medicare supplement contract, eligible persons are those individuals described in subdivision (b) who seek to enroll under the contract during the period specified in subdivision (c), and who submit evidence of the date of termination or disenrollment or enrollment in Medicare Part D with the application for a Medicare supplement contract.

(2) With respect to eligible persons, an issuer shall not take any of the following actions:

1 (A) Deny or condition the issuance or effectiveness of a
2 Medicare supplement contract described in subdivision (e) that is
3 offered and is available for issuance to new enrollees by the
4 issuer.

5 (B) Discriminate in the pricing of that Medicare supplement
6 contract because of health status, claims experience, receipt of
7 health care, or medical condition.

8 (C) Impose an exclusion of benefits based on a preexisting
9 condition under that Medicare supplement contract.

10 (b) An eligible person is an individual described in any of the
11 following paragraphs:

12 (1) The individual is enrolled under an employee welfare
13 benefit plan that provides health benefits that supplement the
14 benefits under Medicare, and the plan either terminates or ceases
15 to provide all of those supplemental health benefits to the
16 individual.

17 (2) The individual is enrolled with a Medicare Advantage
18 organization under a Medicare Advantage plan under Medicare
19 Part C, and any of the following circumstances apply:

20 (A) The certification of the organization or plan has been
21 terminated.

22 (B) The organization has terminated or otherwise discontinued
23 providing the plan in the area in which the individual resides.

24 (C) The individual is no longer eligible to elect the plan
25 because of a change in the individual's place of residence or
26 other change in circumstances specified by the secretary. Those
27 changes in circumstances shall not include termination of the
28 individual's enrollment on the basis described in Section
29 1851(g)(3)(B) of the federal Social Security Act where the
30 individual has not paid premiums on a timely basis or has
31 engaged in disruptive behavior as specified in standards under
32 Section 1856, or the plan is terminated for all individuals within
33 a residence area.

34 (D) The Medicare Advantage plan in which the individual is
35 enrolled reduces any of its benefits or increases the amount of
36 cost sharing or discontinues for other than good cause relating to
37 quality of care, its relationship or contract under the plan with a
38 provider who is currently furnishing services to the individual.
39 An individual shall be eligible under this subparagraph for a
40 Medicare supplement contract issued by the same issuer through

1 which the individual was enrolled at the time of the reduction,
 2 increase, or discontinuance described above occurs or,
 3 commencing January 1, 2007, for one issued by a subsidiary of
 4 the parent company of that issuer or by a network that contracts
 5 with the parent company of that issuer. ~~If no Medicare~~
 6 ~~supplement contract is available from that issuer, the individual~~
 7 ~~shall be eligible for standardized Medicare benefit plans A, B, C,~~
 8 ~~and F (including standardized Medicare supplement high~~
 9 ~~deductible plan F), K, or L from any issuer of one of these plans.~~

10 (E) The individual demonstrates, in accordance with
 11 guidelines established by the secretary, either of the following:

12 (i) The organization offering the plan substantially violated a
 13 material provision of the organization's contract under this article
 14 in relation to the individual, including the failure to provide on a
 15 timely basis medically necessary care for which benefits are
 16 available under the plan or the failure to provide the covered care
 17 in accordance with applicable quality standards.

18 (ii) The organization, or agent or other entity acting on the
 19 organization's behalf, materially misrepresented the plan's
 20 provisions in marketing the plan to the individual.

21 (F) The individual meets other exceptional conditions as the
 22 secretary may provide.

23 (3) The individual is 65 years of age or older, is enrolled with
 24 a Program of All-Inclusive Care for the Elderly (PACE) provider
 25 under Section 1894 of the Social Security Act, and circumstances
 26 similar to those described in paragraph (2) exist that would
 27 permit discontinuance of the individual's enrollment with the
 28 provider, if the individual were enrolled in a Medicare
 29 Advantage plan.

30 (4) The individual meets both of the following conditions:

31 (A) The individual is enrolled with any of the following:

32 (i) An eligible organization under a contract under Section
 33 1876 of the Social Security Act (Medicare cost).

34 (ii) A similar organization operating under demonstration
 35 project authority, effective for periods before April 1, 1999.

36 (iii) An organization under an agreement under Section
 37 1833(a)(1)(A) of the Social Security Act (health care prepayment
 38 plan).

39 (iv) An organization under a Medicare Select policy.

1 (B) The enrollment ceases under the same circumstances that
2 would permit discontinuance of an individual's election of
3 coverage under paragraph (2) or (3).

4 (5) The individual is enrolled under a Medicare supplement
5 contract, and the enrollment ceases because of any of the
6 following circumstances:

7 (A) The insolvency of the issuer or bankruptcy of the
8 nonissuer organization, or other involuntary termination of
9 coverage or enrollment under the contract.

10 (B) The issuer of the contract substantially violated a material
11 provision of the contract.

12 (C) The issuer, or an agent or other entity acting on the
13 issuer's behalf, materially misrepresented the contract's
14 provisions in marketing the contract to the individual.

15 (6) The individual meets both of the following conditions:

16 (A) The individual was enrolled under a Medicare supplement
17 contract and terminates enrollment and subsequently enrolls, for
18 the first time, with any Medicare Advantage organization under a
19 Medicare Advantage plan under Medicare Part C, any eligible
20 organization under a contract under Section 1876 of the Social
21 Security Act (Medicare cost), any similar organization operating
22 under demonstration project authority, any PACE provider under
23 Section 1894 of the Social Security Act, or a Medicare Select
24 policy.

25 (B) The subsequent enrollment under subparagraph (A) is
26 terminated by the individual during any period within the first 12
27 months of the subsequent enrollment (during which the enrollee
28 is permitted to terminate the subsequent enrollment under
29 Section 1851(e) of the federal Social Security Act).

30 (7) The individual upon first becoming eligible for benefits
31 under Medicare Part A at age 65 years of age, enrolls in a
32 Medicare Advantage plan under Medicare Part C or with a PACE
33 provider under Section 1894 of the Social Security Act, and
34 disenrolls from the plan or program not later than 12 months after
35 the effective date of enrollment.

36 (8) The individual while enrolled under a Medicare
37 supplement contract that covers outpatient prescription drugs
38 enrolls in a Medicare Part D plan during the initial enrollment
39 period, terminates enrollment in the Medicare supplement
40 contract, and submits evidence of enrollment in Medicare Part D

1 along with the application for a contract described in
2 ~~subparagraph (B) of paragraph (2) of subdivision (c): paragraph~~
3 ~~(4) of subdivision (e).~~

4 (c) (1) In the case of an individual described in paragraph (1)
5 of subdivision (b), the guaranteed issue period begins on the later
6 of the following two dates and ends on the date that is 63 days
7 after the date the applicable coverage terminated:

8 (A) The date the individual receives a notice of termination or
9 cessation of all supplemental health benefits or, if no notice is
10 received, the date of the notice denying a claim because of a
11 termination or cessation of benefits.

12 (B) The date that the applicable coverage terminates or ceases.

13 (2) In the case of an individual described in paragraphs (2),
14 (3), (4), (6), and (7) of subdivision (b) whose enrollment is
15 terminated involuntarily, the guaranteed issue period begins on
16 the date that the individual receives a notice of termination and
17 ends 63 days after the date the applicable coverage is terminated.

18 (3) In the case of an individual described in subparagraph (A)
19 of paragraph (5) of subdivision (b), the guaranteed issue period
20 begins on the earlier of the following two dates and ends on the
21 date that is 63 days after the date the coverage is terminated:

22 (A) The date that the individual receives a notice of
23 termination, a notice of the issuer's bankruptcy or insolvency, or
24 other similar notice if any.

25 (B) The date that the applicable coverage is terminated.

26 (4) In the case of an individual described in paragraph (2), (3),
27 (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of,
28 subdivision (b) who disenrolls voluntarily, the guaranteed issue
29 period begins on the date that is 60 days before the effective date
30 of the disenrollment and ends on the date that is 63 days after the
31 effective date of the disenrollment.

32 (5) In the case of an individual described in paragraph (8) of
33 subdivision (b), the guaranteed issue period begins on the date
34 the individual receives notice pursuant to Section 1882(v)(2)(B)
35 of the Social Security Act from the Medicare supplement issuer
36 during the 60-day period immediately preceding the initial
37 enrollment period for Medicare Part D and ends on the date that
38 is 63 days after the effective date of the individual's coverage
39 under Medicare Part D.

(6) In the case of an individual described in subdivision (b) who is not included in this subdivision, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(d) (1) In the case of an individual described in paragraph (6) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (6) of subdivision (b).

(2) In the case of an individual described in paragraph (7) of subdivision (b), or deemed to be so described pursuant to this paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b) shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement contract that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement contract in which he or she was most recently enrolled, if available from the same issuer. If that contract is not available, the eligible individual is entitled to a Medicare supplement contract that has

1 a benefit package classified as Plan A, B, C, F (including a high
2 deductible Plan F), K, or L offered by any issuer.

3 (B) On and after January 1, 2006, an eligible individual
4 described in this paragraph who was most recently enrolled in a
5 Medicare supplement contract with an outpatient prescription
6 drug benefit, is entitled to a Medicare supplement contract that is
7 available from the same issuer but without an outpatient
8 prescription drug benefit or, at the election of the individual, has
9 a benefit package classified as a Plan A, B, C, F (including high
10 deductible Plan F), K, or L that is offered by any issuer.

11 (3) Under paragraph (7) of subdivision (b), an eligible
12 individual is entitled to any Medicare supplement contract
13 offered by any issuer.

14 *(4) Under paragraph (8) of subdivision (b), an eligible*
15 *individual is entitled to a Medicare supplement contract that has*
16 *a benefit package classified as Plan A, B, C, F (including a high*
17 *deductible Plan F), K, or L and that is offered and is available*
18 *for issuance to a new enrollee by the same issuer that issued the*
19 *individual's Medicare supplement contract with outpatient*
20 *prescription drug coverage.*

21 (f) (1) At the time of an event described in subdivision (b) by
22 which an individual loses coverage or benefits due to the
23 termination of a contract or agreement, policy, or plan, the
24 organization that terminates the contract or agreement, the issuer
25 terminating the policy or contract, or the administrator of the plan
26 being terminated, respectively, shall notify the individual of his
27 or her rights under this section and of the obligations of issuers of
28 Medicare supplement contracts under subdivision (a). The notice
29 shall be communicated contemporaneously with the notification
30 of termination.

31 (2) At the time of an event described in subdivision (b) by
32 which an individual ceases enrollment under a contract or
33 agreement, policy, or plan, the organization that offers the
34 contract or agreement, regardless of the basis for the cessation of
35 enrollment, the issuer offering the policy or contract, or the
36 administrator of the plan, respectively, shall notify the individual
37 of his or her rights under this section, and of the obligations of
38 issuers of Medicare supplement contracts under subdivision (a).
39 The notice shall be communicated within 10 working days of the
40 date the issuer received notification of disenrollment.

(g) An issuer shall refund any unearned premium that an enrollee or subscriber paid in advance and shall terminate coverage upon the request of an enrollee or subscriber.

SEC. 10. Section 1358.14 of the Health and Safety Code is amended to read:

1358.14. (a) (1) (A) With respect to loss ratio standards, a Medicare supplement contract shall not be advertised, solicited, or issued for delivery unless the contract can be expected, as estimated for the entire period for which prepaid or periodic charges are computed to provide coverage, to return to subscribers and enrollees in the form of aggregate benefits under the contract, not including anticipated refunds or credits provided under the contract, at least 75 percent of the aggregate amount of charges earned in the case of group contracts, or at least 65 percent of the aggregate amount of charges earned in the case of individual contracts, on the basis of incurred claims or costs of health care services experience and earned prepaid or periodic charges for that period and in accordance with accepted actuarial principles and practices.

(B) Loss ratio standards shall be calculated on the basis of incurred health care expenses where coverage is provided by a health care service plan on a service rather than reimbursement basis, and earned prepaid or periodic charges shall be calculated for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health care service plan shall not include any of the following:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to prepaid or periodic charges comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide

coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision (d) of Section 1358.15 only, contracts issued as a result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual contracts.

(b) (1) With respect to refund or credit calculations, an issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form required by the director (NAIC Appendix A) for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of contract offered by the issuer. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to contracts advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual contracts, including all group contracts subject to an individual loss ratio standard when issued, combined and all other group contracts combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars (\$10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against prepaid or periodic charges due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement contracts shall file annually its prepaid or periodic charges and supporting documentation including ratios of incurred losses to earned prepaid or periodic charges by contract duration for approval by

1 the director in accordance with the filing requirements and
2 procedures prescribed by the director. The supporting
3 documentation shall also demonstrate in accordance with
4 actuarial standards of practice using reasonable assumptions that
5 the appropriate loss ratio standards can be expected to be met
6 over the entire period for which charges are computed. The
7 demonstration shall exclude active life reserves. An expected
8 third-year loss ratio that is greater than or equal to the applicable
9 percentage shall be demonstrated for contracts in force less than
10 three years.

11 As soon as practicable, but prior to the effective date of
12 enhancements in Medicare benefits, every issuer of Medicare
13 supplement contracts shall file with the director, in accordance
14 with applicable filing procedures, all of the following:

15 (1) (A) Appropriate prepaid or periodic charge adjustments
16 necessary to produce loss ratios as anticipated for the current
17 charge for the applicable contracts. The supporting documents
18 necessary to justify the adjustment shall accompany the filing.

19 (B) An issuer shall make prepaid or periodic charge
20 adjustments necessary to produce an expected loss ratio under the
21 contract to conform to minimum loss ratio standards for
22 Medicare supplement contracts and that are expected to result in
23 a loss ratio at least as great as that originally anticipated in the
24 rates used to produce current charges by the issuer for the
25 Medicare supplement contracts. No charge adjustment that would
26 modify the loss ratio experience under the contract other than the
27 adjustments described in this section shall be made with respect
28 to a contract at any time other than upon its renewal date or
29 anniversary date.

30 (C) If an issuer fails to make prepaid or periodic charge
31 adjustments acceptable to the director, the director may order
32 charge adjustments, refunds, or credits deemed necessary to
33 achieve the loss ratio required by this section.

34 (2) Any appropriate contract amendments needed to
35 accomplish the Medicare supplement contract modifications
36 necessary to eliminate benefit duplications with Medicare. The
37 contract amendments shall provide a clear description of the
38 Medicare supplement benefits provided by the contract.

39 (d) (1) The director may conduct a public hearing to gather
40 information concerning a request by an issuer for an increase in a

rate for a contract form issued before or after the effective date of January 1, 2001, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

(2) The director may conduct a public hearing to gather information if the experience of the form filed under paragraph (1) of subdivision (b) for the previous reporting period is not in compliance with the applicable loss ratio standard.

The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

SEC. 11. Section 1358.15 of the Health and Safety Code is amended to read:

1358.15. (a) An issuer shall not advertise, solicit, or issue for delivery a Medicare supplement contract to a resident of this state unless the contract has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. Until January 1, 2001, or 90 days after approval of Medicare supplement contracts submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement contracts.

(b) An issuer shall file any riders or amendments to contract forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only in the state where the contract was issued.

(c) An issuer shall not use or change prepaid or periodic charges for a Medicare supplement contract unless the charges and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

(d) (1) Except as provided in paragraph (2), an issuer shall not file for approval more than one contract of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four additional contracts of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits.

(B) The addition of either direct response or agent marketing methods.

(C) The addition of either guaranteed issue or underwritten coverage.

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a “type” means an individual contract, a group contract, an individual Medicare Select contract, or a group Medicare Select contract.

(e) (1) Except as provided in subdivision (a), an issuer shall continue to make available for purchase any contract issued after January 1, 2001, that has been approved by the director. A contract shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(A) An issuer may discontinue the availability of a contract if the issuer provides to the director in writing its decision at least 30 days prior to discontinuing the availability of the form of the contract. After receipt of the notice by the director, the issuer shall no longer offer for sale the contract in this state.

(B) An issuer that discontinues the availability of a contract pursuant to subparagraph (A) shall not file for approval a new contract of the same type for the same standard Medicare supplement benefit plan as the discontinued contract for a period of five years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in

1 which the revised rating methodology and resultant rates differ
2 from the existing rating methodology and existing rates.

3 (B) The issuer does not subsequently put into effect a change
4 of rates or rating factors that would cause the percentage
5 differential between the discontinued and subsequent rates as
6 described in the actuarial memorandum to change. The director
7 may approve a change to the differential that is in the public
8 interest.

9 (f) (1) Except as provided in paragraph (2), the experience of
10 all contracts of the same type in a standard Medicare supplement
11 benefit plan shall be combined for purposes of the refund or
12 credit calculation prescribed in Section 1358.14.

13 (2) Contracts assumed under an assumption reinsurance
14 agreement shall not be combined with the experience of other
15 contracts for purposes of the refund or credit calculation.

16 (g) A Medicare supplement contract shall be deemed not to be
17 fair, just, or consistent with the objectives of this chapter at all
18 times, and shall not be advertised, solicited, or issued for delivery
19 at any time, except during that period of time, if any, beginning
20 with the date of receipt by the plan of notification by the director
21 that the provisions of the contract are deemed to be fair, just, and
22 consistent with the objectives of this chapter, and ending with the
23 earlier to occur of the events indicated in subdivision (h).

24 (h) The period of time indicated in subdivision (g) shall
25 terminate at the earlier to occur of (1) receipt by the plan of
26 written revocation by the director of the immediate past
27 notification referred to in subdivision (g) specifying the basis for
28 the revocation, (2) the last day of the prepaid or periodic charge
29 calculation period, that in no event may exceed one year, or (3)
30 June 30, of the next succeeding calendar year.

31 (i) An issuer shall secure the director's review of a contract
32 subject to this article by submitting, not less than 30 days prior to
33 any proposed advertising or other use of the contract not already
34 protected by a currently effective notice under subdivision (g),
35 the following for the director's review:

36 (1) A copy of the contract.

37 (2) A copy of the disclosure form.

38 (3) A representation that the contract complies with the
39 provisions of this chapter and the rules adopted thereunder.

(4) A completed copy of the “Medicare Supplement Health Care Service Plan Contract Experience Exhibit” set forth in Section 1358.145.

(5) A copy of the calculations for the actual or expected loss ratio.

(6) Supporting data used in calculating the actual or expected loss ratio as indicated in Section 1358.14.

(7) An actuarial certification, as specified in Section 1358.14, of the loss ratio computations.

(8) If required by the director, actuarial certification, as specified in Section 1358.14, of the loss ratio computations by one or more unaffiliated actuaries acceptable to the director.

(9) An undertaking by the issuer to notify the subscribers in writing within 60 days of decertification, if the contract is identified as a certified contract at the time of sale and later decertified.

(10) A signed statement of the president of the issuer or other officer of the issuer designated by that person attesting that the information submitted for review is accurate and complete and does not misrepresent any material fact.

(j) An issuer that submits information pursuant to subdivision (i) shall provide any additional information as may be requested by the director to enable the director to conclude that the contract complies with the provisions of this chapter and rules adopted thereunder.

(k) For the purposes of this section, the term “decertified,” as applied to a contract, means that the director by written notice has found that the contract no longer complies with the provisions of this chapter and the rules adopted thereunder and has revoked the prior authorization to display on the contract the emblem indicating certification.

(l) Benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and the amount of prepaid charges may be modified, as indicated in paragraph (6) of subdivision (a) of Section 1300.67.4 of Title 28 of the California Code of Regulations, to correspond with those changes.

SEC. 12 Section 1358.16 of the Health and Safety Code is amended to read:

1 1358.16. (a) An issuer or other entity may provide a
2 commission or other compensation to a solicitor or other
3 representative for the sale of a Medicare supplement contract
4 only if the first year commission or other first year compensation
5 is no more than 200 percent of the commission or other
6 compensation paid for selling or servicing the contract in the
7 second year or period.

8 (b) The commission or other compensation provided in
9 subsequent renewal years shall be the same as that provided in
10 the second year or period and shall be provided for no fewer than
11 five renewal years.

12 ~~(c) If coverage is replaced, no~~ No issuer shall provide
13 compensation to a solicitor or solicitor firm, and no solicitor or
14 solicitor firm shall receive compensation, ~~in a greater amount~~
15 ~~than the renewal compensation for the replaced coverage payable~~
16 ~~by the replacing issuer on renewal contracts if an existing~~
17 ~~contract is replaced.~~

18 (d) For purposes of this section, “commission” or
19 “compensation” includes pecuniary or nonpecuniary
20 remuneration of any kind relating to the sale or renewal of the
21 contract, including, but not limited to, bonuses, gifts, prizes,
22 awards, and finders’ fees.

23 ~~SEC. 12.—~~

24 *SEC. 13.* Section 1358.17 of the Health and Safety Code is
25 amended to read:

26 1358.17. (a) (1) Medicare supplement contracts shall include
27 a renewal or continuation provision. The language or
28 specifications of the provision shall be consistent with
29 subdivision (a) of Section 1365 and the rules adopted thereunder.
30 The provision shall be appropriately captioned and shall appear
31 on the first page of the contract, and shall include any reservation
32 by the issuer of the right to change prepaid or periodic charges
33 and any automatic renewal increases based on the enrollee’s age.
34 (2) The contract shall contain the provisions required to be set
35 forth by Section 1300.67.4 of Title 28 of the California Code of
36 Regulations.

37 (b) (1) Except for contract amendments by which the issuer
38 effectuates a request made in writing by the enrollee, exercises a
39 specifically reserved right under a Medicare supplement contract,
40 or is required to reduce or eliminate benefits to avoid duplication

1 of Medicare benefits, all amendments to a Medicare supplement
2 contract after the date of issue or upon reinstatement or renewal
3 that reduce or eliminate benefits or coverage in the contract shall
4 require a signed acceptance by the subscriber. After the date of
5 contract issue, any amendment that increases benefits or
6 coverage with a concomitant increase in prepaid or periodic
7 charges during the contract term shall be agreed to in writing
8 signed by the subscriber, unless the benefits are required by the
9 minimum standards for Medicare supplement contracts, or if the
10 increased benefits or coverage is required by law. If a separate
11 additional charge is made for benefits provided in connection
12 with contract amendments, the charge shall be set forth in the
13 contract.

14 (2) An issuer shall not in any way reduce or eliminate any
15 benefit or coverage under a Medicare supplement contract at any
16 time after the date of entering the contract, including dates of
17 reinstatement or renewal, unless and until the change is
18 voluntarily agreed to in writing signed by the subscriber or
19 enrollee, or is required to reduce or eliminate benefits to avoid
20 duplication of Medicare benefits. The issuer shall not increase
21 benefits or coverage with a concomitant increase in prepaid or
22 periodic charges during the term of the contract unless and until
23 the change is voluntarily agreed to in writing signed by the
24 subscriber or enrollee or unless the increased benefits or
25 coverage is required by law or regulation.

26 (c) Medicare supplement contracts shall not provide for the
27 payment of benefits based on standards described as “usual and
28 customary,” “reasonable and customary,” or words of similar
29 import.

30 (d) If a Medicare supplement contract contains any limitations
31 with respect to preexisting conditions, those limitations shall
32 appear as a separate paragraph of the contract and be labeled as
33 “Preexisting Condition Limitations.”

34 (e) (1) Medicare supplement contracts shall have a notice
35 prominently printed in no less than 10-point uppercase type, on
36 the cover page of the contract or attached thereto stating that the
37 applicant shall have the right to return the contract within 30 days
38 of its receipt via regular mail, and to have any charges refunded
39 in a timely manner if, after examination of the contract, the
40 covered person is not satisfied for any reason. The return shall

1 void the contract from the beginning, and the parties shall be in
2 the same position as if no contract had been issued.

3 (2) For purposes of this section, a timely manner shall be no
4 later than 30 days after the issuer receives the returned contract.

5 (3) If the issuer fails to refund all prepaid or periodic charges
6 paid in a timely manner, then the applicant shall receive interest
7 on the paid charges at the legal rate of interest on judgments as
8 provided in Section 685.010 of the Code of Civil Procedure. The
9 interest shall be paid from the date the issuer received the
10 returned contract.

11 (f) (1) Issuers of health care service plan contracts that
12 provide hospital or medical expense coverage on an expense
13 incurred or indemnity basis to persons eligible for Medicare shall
14 provide to those applicants a guide to health insurance for people
15 with Medicare in the form developed jointly by the National
16 Association of Insurance Commissioners and the Centers for
17 Medicare and Medicaid Services and in a type size no smaller
18 than 12-point type. Delivery of the guide shall be made whether
19 or not the contracts are advertised, solicited, or issued for
20 delivery as Medicare supplement contracts as defined in this
21 article. Except in the case of direct response issuers, delivery of
22 the guide shall be made to the applicant at the time of
23 application, and acknowledgment of receipt of the guide shall be
24 obtained by the issuer. Direct response issuers shall deliver the
25 guide to the applicant upon request, but not later than at the time
26 the contract is delivered.

27 (2) For the purposes of this section, “form” means the
28 language, format, type size, type proportional spacing, bold
29 character, and line spacing.

30 (g) As soon as practicable, but no later than 30 days prior to
31 the annual effective date of any Medicare benefit changes, an
32 issuer shall notify its enrollees and subscribers of modifications it
33 has made to Medicare supplement contracts in a format
34 acceptable to the director. The notice shall include both of the
35 following:

36 (1) A description of revisions to the Medicare Program and a
37 description of each modification made to the coverage provided
38 under the Medicare supplement contract.

39 (2) Inform each enrollee as to when any adjustment in prepaid
40 or periodic charges is to be made due to changes in Medicare.

1 (h) The notice of benefit modifications and any adjustments of
2 prepaid or periodic charges shall be in outline form and in clear
3 and simple terms so as to facilitate comprehension.

4 (i) The notices shall not contain or be accompanied by any
5 solicitation.

6 (j) (1) Issuers shall provide an outline of coverage to all
7 applicants at the time application is presented to the prospective
8 applicant and, except for direct response policies, shall obtain an
9 acknowledgment of receipt of the outline from the applicant. If
10 an outline of coverage is provided at the time of application and
11 the Medicare supplement contract is issued on a basis which
12 would require revision of the outline, a substitute outline of
13 coverage properly describing the contract shall accompany the
14 contract when it is delivered and contain the following statement,
15 in no less than 12-point type, immediately above the company
16 name:

17
18 “NOTICE: Read this outline of coverage carefully. It is not
19 identical to the outline of coverage provided upon application
20 and the coverage originally applied for has not been issued.”
21

22 (2) The outline of coverage provided to applicants pursuant to
23 this section consists of four parts: a cover page, information
24 about prepaid or periodic charges, disclosure pages, and charts
25 displaying the features of each benefit plan offered by the issuer.
26 The outline of coverage shall be in the language and format
27 prescribed below in no less than 12-point type. All benefit plans
28 A-L shall be shown on the cover page, and the plans that are
29 offered by the issuer shall be prominently identified. Information
30 about prepaid or periodic charges for plans that are offered shall
31 be shown on the cover page or immediately following the cover
32 page and shall be prominently displayed. The charge and mode
33 shall be stated for all plans that are offered to the prospective
34 applicant. All possible charges for the prospective applicant shall
35 be illustrated.

36 (3) The disclosure pages shall be in the language and format
37 described below in no less than 12-point type.

1 INFORMATION ABOUT PREPAID OR PERIODIC
2 CHARGES
3

4 [Insert plan's name] can only raise your charges if it raises the
5 charge for all contracts like yours in this state. [If the charge is
6 based on the increasing age of the enrollee, include information
7 specifying when charges will change.]
8

9 DISCLOSURES
10

11 Use this outline to compare benefits and charges among
12 policies.
13

14 READ YOUR POLICY VERY CAREFULLY
15

16 This is only an outline describing the most important features
17 of your Medicare supplement plan contract. This is not the plan
18 contract and only the actual contract provisions will control. You
19 must read the contract itself to understand all of the rights and
20 duties of both you and [insert the health care service plan's
21 name].
22

23 RIGHT TO RETURN POLICY
24

25 If you find that you are not satisfied with your contract, you
26 may return it to [insert plan's address]. If you send the contract
27 back to us within 30 days after you receive it, we will treat the
28 contract as if it had never been issued and return all of your
29 payments.
30

31 POLICY REPLACEMENT
32

33 If you are replacing other health coverage, do NOT cancel it
34 until you have actually received your new contract and are sure
35 you want to keep it.

NOTICE

This contract may not fully cover all of your medical costs. Neither [insert the health care service plan's name] nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for further details and limitations applicable to Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information. [If the contract is guaranteed issue, this paragraph need not appear.] Review the application carefully before you sign it. Be certain that all information has been properly recorded. [The charts displaying the features of each benefit plan offered by the issuer shall use the uniform format and language shown in the charts set forth in Section 17 of the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, as most recently adopted by the National Association of Insurance Commissioners. No more than four benefit plans may be shown on one chart. For purposes of illustration, charts for each benefit plan are set forth below. An issuer may use additional benefit plan designations on these charts.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

(k) Notwithstanding Section 1300.63.2 of Title 28 of the California Code of Regulations, no issuer shall combine the evidence of coverage and disclosure form into a single document relating to a contract that supplements Medicare, or is advertised or represented as a supplement to Medicare, with hospital or medical coverage.

(l) The director may adopt regulations to implement this article, including, but not limited to, regulations that specify the

required information to be contained in the outline of coverage provided to applicants pursuant to this section, including the format of tables, charts, and other information.

(m) (1) Any health care service plan contract, other than a Medicare supplement contract, a contract issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability income policy, or any other contract identified in subdivision (b) of Section 1358.3, issued for delivery in this state to persons eligible for Medicare, shall notify enrollees under the contract that the contract is not a Medicare supplement contract. The notice shall either be printed or attached to the first page of the outline of coverage delivered to enrollees under the contract, or if no outline of coverage is delivered, to the first page of the contract delivered to enrollees. The notice shall be in no less than 12-point type and shall contain the following language:

“THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”

(2) Applications provided to persons eligible for Medicare for the health insurance contracts described in paragraph (1) shall disclose the extent to which the contract duplicates Medicare in a manner required by the director. The disclosure statement shall be provided as a part of, or together with, the application for the contract.

(n) A Medicare supplement contract that does not cover custodial care shall, on the cover page of the outline of coverages, contain the following statement in uppercase type: “THIS POLICY DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING CARE FACILITY.”

(o) An issuer shall comply with all notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173).

~~SEC. 13.—~~

SEC. 14. Section 1358.18 of the Health and Safety Code is amended to read:

1 1358.18. In the interest of full and fair disclosure, and to
2 assure the availability of necessary consumer information to
3 potential subscribers or enrollees not possessing a special
4 knowledge of Medicare, health care service plans, or Medicare
5 supplement contracts, an issuer shall comply with the following
6 provisions:

7 (a) Application forms shall include the following questions
8 designed to elicit information as to whether, as of the date of the
9 application, the applicant currently has Medicare supplement,
10 Medicare Advantage, Medi-Cal coverage, or another health
11 insurance policy or certificate or plan contract in force or
12 whether a Medicare supplement contract is intended to replace
13 any other disability policy or certificate, or plan contract,
14 presently in force. A supplementary application or other form to
15 be signed by the applicant and solicitor containing those
16 questions and statements may be used.

17
18 “(Statements)
19

20 (1) You do not need more than one Medicare supplement
21 policy or contract.

22 (2) If you purchase this contract, you may want to evaluate
23 your existing health coverage and decide if you need multiple
24 coverages.

25 (3) You may be eligible for benefits under Medi-Cal or
26 Medicaid and may not need a Medicare supplement contract.

27 (4) If after purchasing this contract you become eligible for
28 Medi-Cal, the benefits and premiums under your Medicare
29 supplement contract can be suspended, if requested, during your
30 entitlement to benefits under Medi-Cal or Medicaid for 24
31 months. You must request this suspension within 90 days of
32 becoming eligible for Medi-Cal or Medicaid. If you are no longer
33 entitled to Medi-Cal or Medicaid, your suspended Medicare
34 supplement contract or if that is no longer available, a
35 substantially equivalent contract, will be reinstituted if requested
36 within 90 days of losing Medi-Cal or Medicaid eligibility. If the
37 Medicare supplement contract provided coverage for outpatient
38 prescription drugs and you enrolled in Medicare Part D while
39 your contract was suspended, the reinstituted contract will not
40 have outpatient prescription drug coverage, but will otherwise be

1 substantially equivalent to your coverage before the date of the
2 suspension.

3 (5) If you are eligible for, and have enrolled in, a Medicare
4 supplement contract by reason of disability and you later become
5 covered by an employer or union-based group health plan, the
6 benefits and premiums under your Medicare supplement contract
7 can be suspended, if requested, while you are covered under the
8 employer or union-based group health plan. If you suspend your
9 Medicare supplement contract under these circumstances and
10 later lose your employer or union-based group health plan, your
11 suspended Medicare supplement contract or if that is no longer
12 available, a substantially equivalent contract, will be reinstituted
13 if requested within 90 days of losing your employer or
14 union-based group health plan. If the Medicare supplement
15 contract provided coverage for outpatient prescription drugs and
16 you enrolled in Medicare Part D while your contract was
17 suspended, the reinstituted contract will not have outpatient
18 prescription drug coverage, but will otherwise be substantially
19 equivalent to your coverage before the date of the suspension.

20 (6) Counseling services are available in this state to provide
21 advice concerning your purchase of Medicare supplement
22 coverage and concerning medical assistance through the
23 Medi-Cal or Medicaid Program, including benefits as a qualified
24 Medicare beneficiary (QMB) and a specified low-income
25 Medicare beneficiary (SLMB). Information regarding counseling
26 services may be obtained from the California Department of
27 Aging.

28
29 (Questions)
30

31 If you lost or are losing other health insurance coverage and
32 received a notice from your prior insurer saying you were
33 eligible for guaranteed issue of a Medicare supplement insurance
34 contract or that you had certain rights to buy such a contract, you
35 may be guaranteed acceptance in one or more of our Medicare
36 supplement plans. Please include a copy of the notice from your
37 prior insurer with your application. PLEASE ANSWER ALL
38 QUESTIONS.

39 [Please mark Yes or No below with an "X."]

40 To the best of your knowledge,

- 1 (1) (a) Did you turn 65 years of age in the last 6 months?
2 Yes ___ No ___
- 3 (b) Did you enroll in Medicare Part B in the last 6 months?
4 Yes ___ No ___
- 5 (c) If yes, what is the effective date? _____
- 6 (2) Are you covered for medical assistance through
7 California's Medi-Cal program?
- 8 NOTE TO APPLICANT: If you have a share of cost under the
9 Medi-Cal program, please answer NO to this question.
10 Yes ___ No ___
- 11 If yes,
- 12 (a) Will Medi-Cal pay your premiums for this Medicare
13 supplement contract?
14 Yes ___ No ___
- 15 (b) Do you receive benefits from Medi-Cal OTHER THAN
16 payments toward your Medicare Part B premium?
17 Yes ___ No ___
- 18 (3) (a) If you had coverage from any Medicare plan other than
19 original Medicare within the past 63 days (for example, a
20 Medicare Advantage plan or a Medicare HMO or PPO), fill in
21 your start and end dates below. If you are still covered under this
22 plan, leave "END" blank.
23 START ___/___/___ END ___/___/___
- 24 (b) If you are still covered under the Medicare plan, do you
25 intend to replace your current coverage with this new Medicare
26 supplement contract?
27 Yes ___ No ___
- 28 (c) Was this your first time in this type of Medicare plan?
29 Yes ___ No ___
- 30 (d) Did you drop a Medicare supplement contract to enroll in
31 the Medicare plan?
32 Yes ___ No ___
- 33 (4) (a) Do you have another Medicare supplement policy or
34 certificate or contract in force?
35 Yes ___ No ___
- 36 (b) If so, with what company, and what plan do you have
37 [optional for Direct Mailers]?
38 Yes ___ No ___
- 39 (c) If so, do you intend to replace your current Medicare
40 supplement policy or certificate or contract with this contract?

Yes _____ No _____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes _____ No _____

(a) If so, with what companies and what kind of policy?

(b) What are your dates of coverage under the other policy?

START ____/____/____ END ____/____/____

(If you are still covered under the other policy, leave “END” blank).

(b) Solicitors shall list any other health insurance policies or plan contracts they have sold to the applicant as follows:

(1) List policies and contracts sold that are still in force.

(2) List policies and contracts sold in the past five years that are no longer in force.

(c) An issuer issuing Medicare supplement contracts without a solicitor or solicitor firm (a direct response issuer) shall return to the applicant, upon delivery of the contract, a copy of the application or supplemental forms, signed by the applicant and acknowledged by the issuer.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement contract, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the contract the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be provided in substantially the following form in no less than 10-point type:

1 NOTICE TO APPLICANT REGARDING REPLACEMENT
2 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
3 ADVANTAGE
4 (Company name and address)
5 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN
6 THE FUTURE
7

8 According to [your application] [information you have
9 furnished], you intend to lapse or otherwise terminate an existing
10 Medicare supplement policy or contract or Medicare Advantage
11 plan and replace it with a contract to be issued by [Plan Name].
12 Your contract to be issued by [Plan Name] will provide 30 days
13 within which you may decide without cost whether you desire to
14 keep the contract. You should review this new coverage
15 carefully. Compare it with all accident and sickness coverage you
16 now have. Terminate your present policy or contract only if, after
17 due consideration, you find that purchase of this Medicare
18 supplement coverage is a wise decision.
19

20 STATEMENT TO APPLICANT BY PLAN, SOLICITOR,
21 SOLICITOR FIRM, OR OTHER REPRESENTATIVE:
22

23 (1) I have reviewed your current medical or health coverage.
24 The replacement of coverage involved in this transaction does
25 not duplicate coverage, to the best of my knowledge. The
26 replacement contract is being purchased for the following reason
27 (check one):

- 28 ☐ Additional benefits.
29 ☐ No change in benefits, but lower premiums or charges.
30 ☐ Fewer benefits and lower premiums or charges.
31 ☐ Plan has outpatient prescription drug coverage and applicant is
32 enrolled in Medicare Part D.
33 ☐ Disenrollment from a Medicare Advantage plan. Reasons for
34 disenrollment:
35 ☐ Other. (please specify) _____

36 (2) You may not be immediately eligible for full coverage
37 under the new contract. This could result in denial or delay of a
38 claim for benefits under the new contract, whereas a similar
39 claim might have been payable under your present policy or
40 contract.

(3) State law provides that your replacement Medicare supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

(4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(5) Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.

(Signature of Solicitor, Solicitor Firm, or Other Representative)
[Typed Name and Address of Plan, Solicitor, or Solicitor Firm]

(Applicant's Signature)

(Date)

(f) The application form or other consumer information for persons eligible for Medicare and used by an issuer shall contain as an attachment a Medicare supplement buyer's guide in the form approved by the director. The application or other consumer information, containing as an attachment the buyer's guide, shall be mailed or delivered to each applicant applying for that coverage at or before the time of application and, to establish compliance with this subdivision, the issuer shall obtain an acknowledgment of receipt of the attached buyer's guide from each applicant. No issuer shall make use of or otherwise disseminate any buyer's guide that does not accurately outline

1 current Medicare supplement benefits. No issuer shall be
2 required to provide more than one copy of the buyer's guide to
3 any applicant.

4 (g) An issuer may comply with the requirement of this section
5 in the case of group contracts by causing the subscriber (1) to
6 disseminate copies of the disclosure form containing as an
7 attachment the buyer's guide to all persons eligible under the
8 group contract at the time those persons are offered the Medicare
9 supplement plan, and (2) collecting and forwarding to the issuer
10 an acknowledgment of receipt of the disclosure form containing
11 as an attachment the buyer's guide from each enrollee.

12 (h) ~~At~~ *Commencing January 1, 2007, an issuer shall not*
13 *require or request health information from an applicant who is*
14 *guaranteed issuance of any Medicare supplement coverage or*
15 *require or request the applicant to sign a form required by the*
16 *federal Health Insurance Portability and Accountability Act of*
17 *1996. The application form shall include a clear and*
18 *conspicuous statement that the applicant is not required to*
19 *provide health information or to sign a form required by the*
20 *federal Health Insurance Portability and Accountability Act of*
21 *1996 during a period of guaranteed issuance of any Medicare*
22 *supplement coverage and shall inform the applicant of periods of*
23 *guaranteed issuance of Medicare supplement coverage. A*
24 *supplementary application or other form containing those*
25 *statements that the applicant and solicitor are required to sign*
26 *may be used for this purpose. This subdivision shall not prohibit*
27 *an issuer from requiring proof of eligibility for a guaranteed*
28 *issuance of Medicare supplement coverage.*

29 ~~SEC. 14.—~~

30 *SEC. 15.* Section 1358.20 of the Health and Safety Code is
31 amended to read:

32 1358.20. (a) An issuer, directly or through solicitors or other
33 representatives, shall do each of the following:

34 (1) Establish marketing procedures to ensure that any
35 comparison of Medicare supplement coverage by its solicitors or
36 other representatives will be fair and accurate.

37 (2) Establish marketing procedures to ensure that excessive
38 coverage is not sold or issued.

1 (3) Display prominently by type, stamp, or other appropriate
2 means, on the first page of the outline of coverage and contract,
3 the following:

4
5 “Notice to buyer: This Medicare supplement contract may not
6 cover all of your medical expenses.”

7
8 (4) Inquire and otherwise make every reasonable effort to
9 identify whether a prospective applicant for a Medicare
10 supplement contract already has health care coverage and the
11 types and amounts of that coverage.

12 (5) Establish auditable procedures for verifying compliance
13 with this subdivision.

14 (b) In addition to the practices prohibited by this code or any
15 other law, the following acts and practices are prohibited:

16 (1) Twisting, which means knowingly making any misleading
17 representation or incomplete or fraudulent comparison of any
18 coverages or issuers for the purpose of inducing or tending to
19 induce, any person to lapse, forfeit, surrender, terminate, retain,
20 pledge, assign, borrow on, or convert any coverage or to take out
21 coverage with another plan or insurer.

22 (2) High pressure tactics, which means employing any method
23 of marketing having the effect of or tending to induce the
24 purchase of coverage through force, fright, threat, whether
25 explicit or implied, or undue pressure to purchase or recommend
26 the purchase of coverage.

27 (3) Cold lead advertising, which means making use directly or
28 indirectly of any method of marketing that fails to disclose in a
29 conspicuous manner that a purpose of the method of marketing is
30 the solicitation of coverage and that contact will be made by a
31 health care service plan or its representative.

32 (c) The terms “Medicare supplement,” “Medigap,” “Medicare
33 Wrap-Around” and words of similar import shall not be used
34 unless the contract is issued in compliance with this article.

35 ~~SEC. 15.—~~

36 *SEC. 16.* Section 1358.21 of the Health and Safety Code is
37 amended to read:

38 1358.21. (a) In recommending the purchase or replacement
39 of any Medicare supplement coverage, an issuer or its

1 representative shall make reasonable efforts to determine the
2 appropriateness of a recommended purchase or replacement.

3 (b) Any sale of a Medicare supplement contract that will
4 provide an individual more than one Medicare supplement policy
5 or certificate, or contract, is prohibited.

6 (c) An issuer shall not issue a Medicare supplement contract to
7 an individual enrolled in Medicare Part C unless the effective
8 date of the coverage is after the termination date of the
9 individual's coverage under Medicare Part C.

10 ~~SEC. 16.—~~

11 *SEC. 17.* Section 10192.4 of the Insurance Code is amended
12 to read:

13 10192.4. The following definitions apply for the purposes of
14 this article:

15 (a) "Applicant" means:

16 (1) The person who seeks to contract for insurance benefits, in
17 the case of an individual Medicare supplement policy.

18 (2) The proposed certificate holder, in the case of a group
19 Medicare supplement policy.

20 (b) "Bankruptcy" means that situation in which a Medicare
21 Advantage organization that is not an issuer has filed, or has had
22 filed against it, a petition for declaration of bankruptcy and has
23 ceased doing business in the state.

24 (c) "Certificate" means a certificate issued for delivery in this
25 state under a group Medicare supplement policy.

26 (d) "Certificate form" means the form on which the certificate
27 is issued for delivery by the issuer.

28 (e) "Continuous period of creditable coverage" means the
29 period during which an individual was covered by creditable
30 coverage, if during the period of the coverage the individual had
31 no breaks in coverage greater than 63 days.

32 (f) (1) "Creditable coverage" means, with respect to an
33 individual, coverage of the individual provided under any of the
34 following:

35 (A) Any individual or group contract, policy, certificate, or
36 program that is written or administered by a health care service
37 plan, health insurer, fraternal benefits society, self-insured
38 employer plan, or any other entity, in this state or elsewhere, and
39 that arranges or provides medical, hospital, and surgical coverage

1 not designed to supplement other private or governmental plans.

2 The term includes continuation or conversion coverage.

3 (B) Part A or B of Title XVIII of the federal Social Security
4 Act (Medicare).

5 (C) Title XIX of the federal Social Security Act (Medicaid),
6 other than coverage consisting solely of benefits under Section
7 1928 of that act.

8 (D) Chapter 55 of Title 10 of the United States Code
9 (CHAMPUS).

10 (E) A medical care program of the Indian Health Service or of
11 a tribal organization.

12 (F) A state health benefits risk pool.

13 (G) A health plan offered under Chapter 89 of Title 5 of the
14 United States Code (Federal Employees Health Benefits
15 Program).

16 (H) A public health plan as defined in federal regulations
17 authorized by Section 2701(c)(1)(I) of the federal Public Health
18 Service Act, as amended by Public Law 104-191, the federal
19 Health Insurance Portability and Accountability Act of 1996.

20 (I) A health benefit plan under Section 5(e) of the federal
21 Peace Corps Act (Section 2504(e) of Title 22 of the United States
22 Code).

23 (J) Any other publicly sponsored program, provided in this
24 state or elsewhere, of medical, hospital, and surgical care.

25 (K) Any other creditable coverage as defined by subsection (c)
26 of Section 2701 of Title XXVII of the federal Public Health
27 Services Act (42 U.S.C. Sec. 300gg(c)).

28 (2) "Creditable coverage" shall not include one or more, or
29 any combination of, the following:

30 (A) Coverage only for accident or disability income insurance,
31 or any combination thereof.

32 (B) Coverage issued as a supplement to liability insurance.

33 (C) Liability insurance, including general liability insurance
34 and automobile liability insurance.

35 (D) Workers' compensation or similar insurance.

36 (E) Automobile medical payment insurance.

37 (F) Credit-only insurance.

38 (G) Coverage for onsite medical clinics.

1 (H) Other similar insurance coverage, specified in federal
2 regulations, under which benefits for medical care are secondary
3 or incidental to other insurance benefits.

4 (3) “Creditable coverage” shall not include the following
5 benefits if they are provided under a separate policy, certificate,
6 or contract of insurance or are otherwise not an integral part of
7 the plan:

8 (A) Limited scope dental or vision benefits.

9 (B) Benefits for long-term care, nursing home care, home
10 health care, community-based care, or any combination thereof.

11 (C) Other similar, limited benefits as are specified in federal
12 regulations.

13 (4) “Creditable coverage” shall not include the following
14 benefits if offered as independent, noncoordinated benefits:

15 (A) Coverage only for a specified disease or illness.

16 (B) Hospital indemnity or other fixed indemnity insurance.

17 (5) “Creditable coverage” shall not include the following if
18 offered as a separate policy, certificate, or contract of insurance:

19 (A) Medicare supplemental health insurance as defined under
20 Section 1882(g)(1) of the federal Social Security Act.

21 (B) Coverage supplemental to the coverage provided under
22 Chapter 55 of Title 10 of the United States Code.

23 (C) Similar supplemental coverage provided to coverage under
24 a group health plan.

25 (g) “Employee welfare benefit plan” means a plan, fund, or
26 program of employee benefits as defined in Section 1002 of Title
27 29 of the United States Code (Employee Retirement Income
28 Security Act).

29 (h) “Insolvency” means when an issuer, licensed to transact
30 the business of insurance in this state, has had a final order of
31 liquidation entered against it with a finding of insolvency by a
32 court of competent jurisdiction in the issuer’s state of domicile.

33 (i) “Issuer” includes insurance companies, fraternal benefit
34 societies, and any other entity delivering, or issuing for delivery,
35 Medicare supplement policies or certificates in this state, except
36 entities subject to Article 3.5 (commencing with Section 1358) of
37 Chapter 2.2 of Division 2 of the Health and Safety Code.

38 (j) “Medicare” means the Health Insurance for the Aged Act,
39 Title XVIII of the Social Security Amendments of 1965, as
40 amended.

(k) “Medicare Advantage plan” means a plan of coverage for health benefits under Medicare Part C and includes:

(1) Coordinated care plans that provide health care services, including, but not limited to, health care service plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organizations plans.

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account.

(3) Medicare Advantage private fee-for-service plans.

(l) “Medicare supplement policy” means a group or individual policy of health insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395mm) or an issued policy under a demonstration project specified in Section 1395ss(g)(1) of Title 42 of the United States Code, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. “Medicare supplement policy” does not include a Medicare Advantage plan established under Medicare Part C, an outpatient prescription drug plan established under Medicare Part D, or a health care prepayment plan that provides benefits pursuant to an agreement under subparagraph (A) of paragraph (1) of subsection (a) of Section 1833 of the Social Security Act.

(m) “Policy form” means the form on which the policy is issued for delivery by the issuer.

(n) “Secretary” means the Secretary of the United States Department of Health and Human Services.

~~SEC. 17.—~~

SEC. 18. Section 10192.5 of the Insurance Code is amended to read:

10192.5. A policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

(a) (1) “Accident,” “accidental injury,” or “accidental means” shall be defined to employ “result” language and shall not include words that establish an accidental means test or use

1 words such as “external, violent, visible wounds” or other similar
2 words of description or characterization.

3 (2) The definition shall not be more restrictive than the
4 following: “injury or injuries for which benefits are provided
5 means accidental bodily injury sustained by the insured person
6 that is the direct result of an accident, independent of disease or
7 bodily infirmity or any other cause, and occurs while insurance
8 coverage is in force.”

9 (3) The definition may provide that injuries shall not include
10 injuries for which benefits are provided or available under any
11 workers’ compensation, employer’s liability, or similar law,
12 unless prohibited by law.

13 (b) “Benefit period” or “Medicare benefit period” shall not be
14 defined more restrictively than as defined in the Medicare
15 Program.

16 (c) “Convalescent nursing home,” “extended care facility,” or
17 “skilled nursing facility” shall not be defined more restrictively
18 than as defined in the Medicare Program.

19 (d) (1) “Health care expenses” means expenses of health
20 maintenance organizations associated with the delivery of health
21 care services, which expenses are analogous to incurred losses of
22 insurers.

23 (2) “Health care expenses” shall not include any of the
24 following:

25 (A) Home office and overhead costs.

26 (B) Advertising costs.

27 (C) Commissions and other acquisition costs.

28 (D) Taxes.

29 (E) Capital costs.

30 (F) Administrative costs.

31 (G) Claims processing costs.

32 (e) “Hospital” may be defined in relation to its status,
33 facilities, and available services or to reflect its accreditation by
34 the Joint Commission on Accreditation of Hospitals, but not
35 more restrictively than as defined in the Medicare Program.

36 (f) “Medicare” shall be defined in the policy and certificate.
37 “Medicare” may be substantially defined as “The Health
38 Insurance for the Aged Act, Title XVIII of the Social Security
39 Amendments of 1965, as amended,” or “Title I, Part I of Public
40 Law 89-97, as enacted by the 89th Congress and popularly

known as the Health Insurance for the Aged Act, as amended,” or words of similar import.

(g) “Medicare eligible expenses” shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(h) “Physician” shall not be defined more restrictively than as defined in the Medicare Program.

(i) (1) “Sickness” shall not be defined more restrictively than as follows: “sickness means illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force.”

(2) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability, or similar law.

~~SEC. 18.—~~

SEC. 19. Section 10192.6 of the Insurance Code is amended to read:

10192.6. (a) Except for permitted preexisting condition clauses as described in Sections 10192.7 and 10192.8, a policy or certificate shall not be advertised, solicited, or issued for delivery as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) A Medicare supplement policy or certificate shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) A Medicare supplement policy or certificate in force shall not contain benefits that duplicate benefits provided by Medicare.

(d) (1) Subject to paragraphs (4) and (5) of subdivision (a) of Section 10192.8, a Medicare supplement policy with benefits for outpatient prescription drugs that was issued prior to January 1, 2006, shall be renewed for current policyholders, at the option of the policyholder, who do not enroll in Medicare Part D.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued on and after January 1, 2006.

(3) On and after January 1, 2006, a Medicare supplement policy with benefits for outpatient prescription drugs shall not be

1 renewed after the policyholder enrolls in Medicare Part D unless
2 both of the following conditions exist:

3 (A) The policy is modified to eliminate outpatient prescription
4 drug coverage for outpatient prescription drug expenses incurred
5 after the effective date of the individual's coverage under a
6 Medicare Part D plan.

7 (B) The premium is adjusted to reflect the elimination of
8 outpatient prescription drug coverage at the time of enrollment in
9 Medicare Part D, accounting for any claims paid if applicable.

10 ~~SEC. 19.—~~

11 *SEC. 20.* Section 10192.8 of the Insurance Code is amended
12 to read:

13 10192.8. The following standards are applicable to all
14 Medicare supplement policies or certificates advertised, solicited,
15 or issued for delivery on or after January 1, 2001. A policy or
16 certificate shall not be advertised, solicited, or issued for delivery
17 as a Medicare supplement policy or certificate unless it complies
18 with these benefit standards.

19 (a) The following general standards apply to Medicare
20 supplement policies and certificates and are in addition to all
21 other requirements of this article:

22 (1) A Medicare supplement policy or certificate shall not
23 exclude or limit benefits for losses incurred more than six months
24 from the effective date of coverage because it involved a
25 preexisting condition. The policy or certificate shall not define a
26 preexisting condition more restrictively than a condition for
27 which medical advice was given or treatment was recommended
28 by or received from a physician within six months before the
29 effective date of coverage.

30 (2) A Medicare supplement policy or certificate shall not
31 indemnify against losses resulting from sickness on a different
32 basis than losses resulting from accidents.

33 (3) A Medicare supplement policy or certificate shall provide
34 that benefits designed to cover cost-sharing amounts under
35 Medicare will be changed automatically to coincide with any
36 changes in the applicable Medicare deductible amount and
37 copayment percentage factors. Premiums may be modified to
38 correspond with those changes.

39 (4) A Medicare supplement policy or certificate shall not
40 provide for termination of coverage of a spouse solely because of

1 the occurrence of an event specified for termination of coverage
2 of the insured, other than the nonpayment of premium.

3 (5) Each Medicare supplement policy shall be guaranteed
4 renewable or noncancelable.

5 (A) The issuer shall not cancel or nonrenew the policy solely
6 on the ground of health status of the individual.

7 (B) The issuer shall not cancel or nonrenew the policy for any
8 reason other than nonpayment of premium or misrepresentation
9 which is shown by the issuer to be material to the acceptance for
10 coverage. The contestability period for Medicare supplement
11 insurance shall be two years.

12 (C) If the Medicare supplement policy is terminated by the
13 master policyholder and is not replaced as provided under
14 subparagraph (E), the issuer shall offer certificate holders an
15 individual Medicare supplement policy that, at the option of the
16 certificate holder, either provides for continuation of the benefits
17 contained in the group policy or provides for benefits that
18 otherwise meet the requirements of one of the standardized
19 policies defined in this article.

20 (D) If an individual is a certificate holder in a group Medicare
21 supplement policy and membership in the group is terminated,
22 the issuer shall either offer the certificate holder the conversion
23 opportunity described in subparagraph (C) or, at the option of the
24 group policyholder, shall offer the certificate holder continuation
25 of coverage under the group policy.

26 (E) (i) If a group Medicare supplement policy is replaced by
27 another group Medicare supplement policy purchased by the
28 same policyholder, the issuer of the replacement policy shall
29 offer coverage to all persons covered under the old group policy
30 on its date of termination. Coverage under the new policy shall
31 not result in any exclusion for preexisting conditions that would
32 have been covered under the group policy being replaced.

33 (ii) If a Medicare supplement policy or certificate replaces
34 another Medicare supplement policy or certificate that has been
35 in force for six months or more, the replacing issuer shall not
36 impose an exclusion or limitation based on a preexisting
37 condition. If the original coverage has been in force for less than
38 six months, the replacing issuer shall waive any time period
39 applicable to preexisting conditions, waiting periods, elimination

1 periods, or probationary periods in the new policy or certificate
2 to the extent the time was spent under the original coverage.

3 (F) If a Medicare supplement policy eliminates an outpatient
4 prescription drug benefit as a result of requirements imposed by
5 the Medicare Prescription Drug, Improvement, and
6 Modernization Act of 2003 (P.L. 108-173), the policy as
7 modified as a result of that act shall be deemed to satisfy the
8 guaranteed renewal requirements of this paragraph.

9 (6) Termination of a Medicare supplement policy or certificate
10 shall be without prejudice to any continuous loss that
11 commenced while the policy was in force, but the extension of
12 benefits beyond the period during which the policy was in force
13 may be predicated upon the continuous total disability of the
14 insured, limited to the duration of the policy benefit period, if
15 any, or to payment of the maximum benefits. Receipt of
16 Medicare Part D benefits shall not be considered in determining
17 a continuous loss.

18 (7) (A) (i) A Medicare supplement policy or certificate shall
19 provide that benefits and premiums under the policy or certificate
20 shall be suspended at the request of the policyholder or certificate
21 holder for the period, not to exceed 24 months, in which the
22 policyholder or certificate holder has applied for and is
23 determined to be entitled to Medi-Cal or Medicaid under Title
24 XIX of the federal Social Security Act, but only if the
25 policyholder or certificate holder notifies the issuer of the policy
26 or certificate within 90 days after the date the individual becomes
27 entitled to assistance. Upon receipt of timely notice, the insurer
28 shall return directly to the insured that portion of the premium
29 attributable to the period of Medi-Cal or Medicaid eligibility,
30 subject to adjustment for paid claims. If suspension occurs and if
31 the policyholder or certificate holder loses entitlement to
32 Medi-Cal or Medicaid, the policy or certificate shall be
33 automatically reinstituted, effective as of the date of termination
34 of entitlement, as of the termination of entitlement if the
35 policyholder or certificate holder provides notice of loss of
36 entitlement within 90 days after the date of loss and pays the
37 premium attributable to the period, effective as of the date of
38 termination of entitlement, or equivalent coverage shall be
39 provided if the prior form is no longer available.

(ii) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for any period that may be provided by federal regulation if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and the policyholder or certificate holder loses coverage under the group health plan, the policy or certificate shall be automatically reinstituted, effective as of the date of loss of coverage if the policyholder provides notice within 90 days of the date of the loss of coverage.

(B) Reinstitution of coverages:

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions.

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for a Medicare Part D enrollee shall not include coverage for outpatient prescription drugs but shall otherwise provide coverage that is substantially equivalent to the coverage in effect before the date of suspension.

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(8) No Medicare supplement policy may limit coverage exclusively to a single disease or affliction.

(b) With respect to the standards for basic (core) benefits for benefit plans A to J, inclusive, every issuer shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. However, the benefits described in paragraphs (6) and (7) shall not be offered so long as California is required to disallow these benefits for Medicare beneficiaries by the Centers for Medicare and Medicaid Services or other

1 agent of the federal government under Section 1395ss of Title 42
2 of the United States Code.

3 (1) Coverage of Part A Medicare eligible expenses for
4 hospitalization to the extent not covered by Medicare from the
5 61st day to the 90th day, inclusive, in any Medicare benefit
6 period.

7 (2) Coverage of Part A Medicare eligible expenses incurred
8 for hospitalization to the extent not covered by Medicare for each
9 Medicare lifetime inpatient reserve day used.

10 (3) Upon exhaustion of the Medicare hospital inpatient
11 coverage including the lifetime reserve days, coverage of 100
12 percent of the Medicare Part A eligible expenses for
13 hospitalization paid at the appropriate Medicare standard of
14 payment, subject to a lifetime maximum benefit of an additional
15 365 days. The provider shall accept the issuer's payment as
16 payment in full and may not bill the insured for any balance.

17 (4) Coverage under Medicare Parts A and B for the reasonable
18 cost of the first three pints of blood, or equivalent quantities of
19 packed red blood cells, as defined under federal regulations,
20 unless replaced in accordance with federal regulations.

21 (5) Coverage for the coinsurance amount, or in the case of
22 hospital outpatient department services, the copayment amount,
23 of Medicare eligible expenses under Part B regardless of hospital
24 confinement, subject to the Medicare Part B deductible.

25 (6) Coverage of the actual cost, up to the legally billed
26 amount, of an annual mammogram as provided in Section
27 10123.81, to the extent not paid by Medicare.

28 (7) Coverage of the actual cost, up to the legally billed
29 amount, of an annual cervical cancer screening test as provided
30 in Section 10123.18, to the extent not paid by Medicare.

31 (c) The following additional benefits shall be included in
32 Medicare supplement benefit plans B to J, inclusive, only as
33 provided by Section 10192.9.

34 (1) With respect to the Medicare Part A deductible, coverage
35 for all of the Medicare Part A inpatient hospital deductible
36 amount per benefit period.

37 (2) With respect to skilled nursing facility care, coverage for
38 the actual billed charges up to the coinsurance amount from the
39 21st day to the 100th day, inclusive, in a Medicare benefit period

1 for posthospital skilled nursing facility care eligible under
2 Medicare Part A.

3 (3) With respect to the Medicare Part B deductible, coverage
4 for all of the Medicare Part B deductible amount per calendar
5 year regardless of hospital confinement.

6 (4) With respect to 80 percent of the Medicare Part B excess
7 charges, coverage for 80 percent of the difference between the
8 actual Medicare Part B charge as billed, not to exceed any charge
9 limitation established by the Medicare Program or state law, and
10 the Medicare-approved Part B charge. If the insurer limits
11 payment to a limiting charge, the insurer has the burden to
12 establish that amount as the legal limit.

13 (5) With respect to 100 percent of the Medicare Part B excess
14 charges, coverage for all of the difference between the actual
15 Medicare Part B charge as billed, not to exceed any charge
16 limitation established by the Medicare Program or state law, and
17 the Medicare-approved Part B charge. If the insurer limits
18 payment to a limiting charge, the insurer has the burden to
19 establish that amount as the legal limit.

20 (6) With respect to the basic outpatient prescription drug
21 benefit, coverage for 50 percent of outpatient prescription drug
22 charges, after a two hundred fifty dollar (\$250) calendar year
23 deductible, to a maximum of one thousand two hundred fifty
24 dollars (\$1,250) in benefits received by the insured per calendar
25 year, to the extent not covered by Medicare. On and after January
26 1, 2006, no Medicare supplement policy may be sold or issued if
27 it includes a prescription drug benefit.

28 (7) With respect to the extended outpatient prescription drug
29 benefit, coverage for 50 percent of outpatient prescription drug
30 charges, after a two hundred fifty dollar (\$250) calendar year
31 deductible, to a maximum of three thousand dollars (\$3,000) in
32 benefits received by the insured per calendar year, to the extent
33 not covered by Medicare. On and after January 1, 2006, no
34 Medicare supplement policy may be sold or issued if it includes
35 a prescription drug benefit.

36 (8) With respect to medically necessary emergency care in a
37 foreign country, coverage to the extent not covered by Medicare
38 for 80 percent of the billed charges for Medicare-eligible
39 expenses for medically necessary emergency hospital, physician,
40 and medical care received in a foreign country, which care would

1 have been covered by Medicare if provided in the United States
2 and which care began during the first 60 consecutive days of
3 each trip outside the United States, subject to a calendar year
4 deductible of two hundred fifty dollars (\$250), and a lifetime
5 maximum benefit of fifty thousand dollars (\$50,000). For
6 purposes of this benefit, “emergency care” shall mean care
7 needed immediately because of an injury or an illness of sudden
8 and unexpected onset.

9 (9) With respect to the following, reimbursement shall be for
10 the actual charges up to 100 percent of the Medicare-approved
11 amount for each service, as if Medicare were to cover the service
12 as identified in American Medical Association Current
13 Procedural Terminology (AMA CPT) codes, up to a maximum of
14 one hundred twenty dollars (\$120) annually under this benefit,
15 however, this benefit shall not include payment for any
16 procedure covered by Medicare:

17 (A) An annual clinical preventive medical history and physical
18 examination that may include tests and services from
19 subparagraph (B) and patient education to address preventive
20 health care measures.

21 (B) The following screening tests or preventive services that
22 are not covered by Medicare, the selection and frequency of
23 which are determined to be medically appropriate by the
24 attending physician:

25 (i) Fecal occult blood test.

26 (ii) Mammogram.

27 (C) Influenza vaccine administered at any appropriate time
28 during the year.

29 (10) With respect to the at-home recovery benefit, coverage
30 for the actual charges up to forty dollars (\$40) per visit and an
31 annual maximum of one thousand six hundred dollars (\$1,600)
32 per year to provide short-term, at-home assistance with activities
33 of daily living for those recovering from an illness, injury, or
34 surgery.

35 (A) For purposes of this benefit, the following definitions shall
36 apply:

37 (i) “Activities of daily living” include, but are not limited to,
38 bathing, dressing, personal hygiene, transferring, eating,
39 ambulating, assistance with drugs that are normally
40 self-administered, and changing bandages or other dressings.

1 (ii) “Care provider” means a duly qualified or licensed home
2 health aide or homemaker, or a personal care aide or nurse
3 provided through a licensed home health care agency or referred
4 by a licensed referral agency or licensed nurses registry.

5 (iii) “Home” shall mean any place used by the insured as a
6 place of residence, provided that the place would qualify as a
7 residence for home health care services covered by Medicare. A
8 hospital or skilled nursing facility shall not be considered the
9 insured’s place of residence.

10 (iv) “At-home recovery visit” means the period of a visit
11 required to provide at-home recovery care, without any limit on
12 the duration of the visit, except that each consecutive four hours
13 in a 24-hour period of services provided by a care provider is one
14 visit.

15 (B) With respect to coverage requirements and limitations, the
16 following shall apply:

17 (i) At-home recovery services provided shall be primarily
18 services that assist in activities of daily living.

19 (ii) The insured’s attending physician shall certify that the
20 specific type and frequency of at-home recovery services are
21 necessary because of a condition for which a home care plan of
22 treatment was approved by Medicare.

23 (iii) Coverage is limited to the following:

24 (I) No more than the number and type of at-home recovery
25 visits certified as necessary by the insured’s attending physician.
26 The total number of at-home recovery visits shall not exceed the
27 number of Medicare-approved home health care visits under a
28 Medicare-approved home care plan of treatment.

29 (II) The actual charges for each visit up to a maximum
30 reimbursement of forty dollars (\$40) per visit.

31 (III) One thousand six hundred dollars (\$1,600) per calendar
32 year.

33 (IV) Seven visits in any one week.

34 (V) Care furnished on a visiting basis in the insured’s home.

35 (VI) Services provided by a care provider as defined in
36 subparagraph (A).

37 (VII) At-home recovery visits while the insured is covered
38 under the policy or certificate and not otherwise excluded.

39 (VIII) At-home recovery visits received during the period the
40 insured is receiving Medicare-approved home care services or no

1 more than eight weeks after the service date of the last
2 Medicare-approved home health care visit.

3 (C) Coverage is excluded for the following:

4 (i) Home care visits paid for by Medicare or other government
5 programs.

6 (ii) Care provided by family members, unpaid volunteers, or
7 providers who are not care providers.

8 (d) The standardized Medicare supplement benefit plan “K”
9 shall consist of the following benefits:

10 (1) Coverage of 100 percent of the Medicare Part A hospital
11 coinsurance amount for each day used from the 61st to the 90th
12 day, inclusive, in any Medicare benefit period.

13 (2) Coverage of 100 percent of the Medicare Part A hospital
14 coinsurance amount for each Medicare lifetime inpatient reserve
15 day used from the 91st to the 150th day, inclusive, in any
16 Medicare benefit period.

17 (3) Upon exhaustion of the Medicare hospital inpatient
18 coverage, including the lifetime reserve days, coverage of 100
19 percent of the Medicare Part A eligible expenses for
20 hospitalization paid at the applicable prospective payment system
21 rate, or other appropriate Medicare standard of payment, subject
22 to a lifetime maximum benefit of an additional 365 days. The
23 provider shall accept the issuer’s payment for this benefit as
24 payment in full and shall not bill the insured for any balance.

25 (4) With respect to the Medicare Part A deductible, coverage
26 for 50 percent of the Medicare Part A inpatient hospital
27 deductible amount per benefit period until the out-of-pocket
28 limitation described in paragraph (10) is met.

29 (5) With respect to skilled nursing facility care, coverage for
30 50 percent of the coinsurance amount for each day used from the
31 21st day to the 100th day, inclusive, in a Medicare benefit period
32 for posthospital skilled nursing facility care eligible under
33 Medicare Part A until the out-of-pocket limitation described in
34 paragraph (10) is met.

35 (6) With respect to hospice care, coverage for 50 percent of
36 cost sharing for all Medicare Part A eligible expenses and respite
37 care until the out-of-pocket limitation described in paragraph
38 (10) is met.

39 (7) Coverage for 50 percent, under Medicare Part A or B, of
40 the reasonable cost of the first three pints of blood or equivalent

1 quantities of packed red blood cells, as defined under federal
2 regulations, unless replaced in accordance with federal
3 regulations, until the out-of-pocket limitation described in
4 paragraph (10) is met.

5 (8) Except for coverage provided in paragraph (9), coverage
6 for 50 percent of the cost sharing otherwise applicable under
7 Medicare Part B after the policyholder pays the Part B
8 deductible, until the out-of-pocket limitation is met as described
9 in paragraph (10).

10 (9) Coverage of 100 percent of the cost sharing for Medicare
11 Part B preventive services, after the policyholder pays the
12 Medicare Part B deductible.

13 (10) Coverage of 100 percent of all cost sharing under
14 Medicare Parts A and B for the balance of the calendar year after
15 the individual has reached the out-of-pocket limitation on annual
16 expenditures under Medicare Parts A and B of four thousand
17 dollars (\$4,000) in 2006, indexed each year by the appropriate
18 inflation adjustment specified by the secretary.

19 (e) The standardized Medicare supplement benefit plan “L”
20 shall consist of the following benefits:

21 (1) The benefits described in paragraphs (1), (2), (3), and (9)
22 of subdivision (d).

23 (2) With respect to the Medicare Part A deductible, coverage
24 for 75 percent of the Medicare Part A inpatient hospital
25 deductible amount per benefit period until the out-of-pocket
26 limitation described in paragraph (8) is met.

27 (3) With respect to skilled nursing facility care, coverage for
28 75 percent of the coinsurance amount for each day used from the
29 21st day to the 100th day, inclusive, in a Medicare benefit period
30 for posthospital skilled nursing facility care eligible under
31 Medicare Part A until the out-of-pocket limitation described in
32 paragraph (8) is met.

33 (4) With respect to hospice care, coverage for 75 percent of
34 cost sharing for all Medicare Part A eligible expenses and respite
35 care until the out-of-pocket limitation described in paragraph (8)
36 is met.

37 (5) Coverage for 75 percent, under Medicare Part A or B, of
38 the reasonable cost of the first three pints of blood or equivalent
39 quantities of packed red blood cells, as defined under federal
40 regulations, unless replaced in accordance with federal

1 regulations, until the out-of-pocket limitation described in
2 paragraph (8) is met.

3 (6) Except for coverage provided in paragraph (7), coverage
4 for 75 percent of the cost sharing otherwise applicable under
5 Medicare Part B after the policyholder pays the Part B deductible
6 until the out-of-pocket limitation described in paragraph (8) is
7 met.

8 (7) Coverage for 100 percent of the cost sharing for Medicare
9 Part B preventive services after the policyholder pays the Part B
10 deductible.

11 (8) Coverage of 100 percent of the cost sharing for Medicare
12 Parts A and B for the balance of the calendar year after the
13 individual has reached the out-of-pocket limitation on annual
14 expenditures under Medicare Parts A and B of two thousand
15 dollars (\$2,000) in 2006, indexed each year by the appropriate
16 inflation adjustment specified by the secretary.

17 *(f) An issuer shall prominently indicate through text edits, or*
18 *by other means acceptable to the commissioner, an amendment*
19 *made to a Medicare supplement policy form that the department*
20 *previously approved on the basis that the amendment is*
21 *consistent with this section. The department may, in its*
22 *discretion, restrict its review to amendments made to Medicare*
23 *supplement policy forms that have not previously been found*
24 *consistent with this section in order to facilitate the availability*
25 *of amended policy forms that are consistent with the federal*
26 *Medicare Modernization Act. The department shall not restrict*
27 *its review if the amendment makes additional changes to the*
28 *Medicare supplement policy form.*

29 ~~SEC. 20.—~~

30 *SEC. 21.* Section 10192.9 of the Insurance Code is amended
31 to read:

32 10192.9. (a) An issuer shall make available to each
33 prospective policyholder and certificate holder a policy form or
34 certificate form containing only the basic (core) benefits, as
35 defined in subdivision (b) of Section 10192.8.

36 (b) No groups, packages, or combinations of Medicare
37 supplement benefits other than those listed in this section shall be
38 offered for sale in this state, except as may be permitted by
39 subdivision (f) and by Section 10192.10.

1 (c) Benefit plans shall be uniform in structure, language,
2 designation and format to the standard benefit plans A to J,
3 inclusive, listed in subdivision (e), and shall conform to the
4 definitions in Section 10192.4. Each benefit shall be structured in
5 accordance with the format provided in subdivisions (b), (c), (d),
6 and (e) of Section 10192.8 and list the benefits in the order listed
7 in subdivision (e). For purposes of this section, “structure,
8 language, and format” means style, arrangement, and overall
9 content of a benefit.

10 (d) An issuer may use, in addition to the benefit plan
11 designations required in subdivision (c), other designations to the
12 extent permitted by law.

13 (e) With respect to the makeup of benefit plans, the following
14 shall apply:

15 (1) Standardized Medicare supplement benefit plan A shall be
16 limited to the basic (core) benefit common to all benefit plans, as
17 defined in subdivision (b) of Section 10192.8.

18 (2) Standardized Medicare supplement benefit plan B shall
19 include only the following: the core benefit, plus the Medicare
20 Part A deductible as defined in paragraph (1) of subdivision (c)
21 of Section 10192.8.

22 (3) Standardized Medicare supplement benefit plan C shall
23 include only the following: the core benefit, plus the Medicare
24 Part A deductible, skilled nursing facility care, Medicare Part B
25 deductible, and medically necessary emergency care in a foreign
26 country as defined in paragraphs (1), (2), (3), and (8) of
27 subdivision (c) of Section 10192.8, respectively.

28 (4) Standardized Medicare supplement benefit plan D shall
29 include only the following: the core benefit, plus the Medicare
30 Part A deductible, skilled nursing facility care, medically
31 necessary emergency care in a foreign country, and the at-home
32 recovery benefit as defined in paragraphs (1), (2), (8), and (10) of
33 subdivision (c) of Section 10192.8, respectively.

34 (5) Standardized Medicare supplement benefit plan E shall
35 include only the following: the core benefit, plus the Medicare
36 Part A deductible, skilled nursing facility care, medically
37 necessary emergency care in a foreign country, and preventive
38 medical care as defined in paragraphs (1), (2), (8), and (9) of
39 subdivision (c) of Section 10192.8, respectively.

(6) Standardized Medicare supplement benefit plan F shall include only the following: the core benefit, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (3), (5), and (8) of subdivision (c) of Section 10192.8, respectively. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be one thousand five hundred dollars (\$1,500) for 1998 and 1999, and shall be based on the calendar year, as adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(8) Standardized Medicare supplement benefit plan G shall include only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (1), (2), (4), (8), and (10) of Section 10192.8, respectively.

(9) Standardized Medicare supplement benefit plan H shall consist of only the following: the core benefit, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs (1), (2), (6), and (8) of Section 10192.8, respectively. The outpatient

1 prescription drug benefit shall not be included in a Medicare
2 supplement policy sold on or after January 1, 2006.

3 (10) Standardized Medicare supplement benefit plan I shall
4 consist of only the following: the core benefit, plus the Medicare
5 Part A deductible, skilled nursing facility care, 100 percent of the
6 Medicare Part B excess charges, basic outpatient prescription
7 drug benefit, medically necessary emergency care in a foreign
8 country, and at-home recovery benefit as defined in paragraphs
9 (1), (2), (5), (6), (8), and (10) of subdivision (c) of Section
10 10192.8, respectively. The outpatient prescription drug benefit
11 shall not be included in a Medicare supplement policy sold on or
12 after January 1, 2006.

13 (11) Standardized Medicare supplement benefit plan J shall
14 consist of only the following: the core benefit, plus the Medicare
15 Part A deductible, skilled nursing facility care, Medicare Part B
16 deductible, 100 percent of the Medicare Part B excess charges,
17 extended outpatient prescription drug benefit, medically
18 necessary emergency care in a foreign country, preventive
19 medical care, and at-home recovery benefit as defined in
20 paragraphs (1), (2), (3), (5), (7), (8), (9), and (10) of subdivision
21 (c) of Section 10192.8, respectively. The outpatient prescription
22 drug benefit shall not be included in a Medicare supplement
23 policy sold on or after January 1, 2006.

24 (12) Standardized Medicare supplement benefit high
25 deductible plan J shall consist of only the following: 100 percent
26 of covered expenses following the payment of the annual high
27 deductible plan J deductible. The covered expenses include the
28 core benefit, plus the Medicare Part A deductible, skilled nursing
29 facility care, Medicare Part B deductible, 100 percent of the
30 Medicare Part B excess charges, extended outpatient prescription
31 drug benefit, medically necessary emergency care in a foreign
32 country, preventive medical care benefit, and at-home recovery
33 benefit as defined in paragraphs (1), (2), (3), (5), (7), (8), (9), and
34 (10) of subdivision (c) of Section 10192.8, respectively. The
35 annual high deductible plan J deductible shall consist of
36 out-of-pocket expenses, other than premiums, for services
37 covered by the Medicare supplement plan J policy, and shall be
38 in addition to any other specific benefit deductibles. The annual
39 deductible shall be one thousand five hundred dollars (\$1,500)
40 for 1998 and 1999, and shall be based on a calendar year, as

1 adjusted annually thereafter by the secretary to reflect the change
2 in the Consumer Price Index for all urban consumers for the
3 12-month period ending with August of the preceding year, and
4 rounded to the nearest multiple of ten dollars (\$10). The
5 outpatient prescription drug benefit shall not be included in a
6 Medicare supplement policy sold on or after January 1, 2006.

7 (13) Standardized Medicare supplement benefit plan K shall
8 consist of only those benefits described in subdivision (d) of
9 Section 10192.8.

10 (14) Standardized Medicare supplement benefit plan L shall
11 consist of only those benefits described in subdivision (e) of
12 Section 10192.8.

13 (f) An issuer may, with the prior approval of the
14 commissioner, offer policies or certificates with new or
15 innovative benefits in addition to the benefits provided in a
16 policy or certificate that otherwise complies with the applicable
17 standards. The new or innovative benefits may include benefits
18 that are appropriate to Medicare supplement insurance, that are
19 not otherwise available and that are cost-effective and offered in
20 a manner that is consistent with the goal of simplification of
21 Medicare supplement policies. On and after January 1, 2006, the
22 innovative benefit shall not include an outpatient prescription
23 drug benefit.

24 ~~SEC. 21.—~~

25 *SEC. 22.* Section 10192.10 of the Insurance Code is amended
26 to read:

27 10192.10. (a) (1) This section shall apply to Medicare Select
28 policies and certificates, as defined in this section.

29 (2) A policy or certificate shall not be advertised as a
30 Medicare Select policy or certificate unless it meets the
31 requirements of this section.

32 (b) For the purposes of this section:

33 (1) “Appeal” means dissatisfaction expressed in writing by an
34 individual insured under a Medicare Select policy or certificate
35 with the administration, claims practices, or provision of services
36 concerning a Medicare Select issuer or its network providers.

37 (2) “Complaint” means any dissatisfaction expressed by an
38 individual concerning a Medicare Select issuer or its network
39 providers.

1 (3) “Medicare Select issuer” means an issuer offering, seeking
2 to offer, advertising, marketing, soliciting, or issuing a Medicare
3 Select policy or certificate.

4 (4) “Medicare Select policy” or “Medicare Select certificate”
5 means respectively a Medicare supplement policy or certificate
6 that contains restricted network provisions.

7 (5) “Network provider” means a provider of health care, or a
8 group of providers of health care, which has entered into a
9 written agreement with the issuer or other entity to provide
10 benefits insured under a Medicare Select policy.

11 (6) “Restricted network provision” means any provision that
12 conditions the payment of benefits, in whole or in part, on the use
13 of network providers.

14 (7) “Service area” means the geographic area approved by the
15 commissioner within which an issuer is authorized to offer a
16 Medicare Select policy.

17 (8) “Grievance” means a written complaint registered by an
18 individual for resolution under the formal grievance procedure,
19 which may involve, but is not limited to, the administration,
20 claims practices, or provision of services by the issuer or its
21 network providers.

22 (9) “Medicare Select coverage” means Medicare supplement
23 coverage through a preferred provider organization or any other
24 type of restricted network, which coverage has been approved by
25 the commissioner under this section.

26 (10) “Preferred provider organization” means a health care
27 provider or an entity contracting with health care providers that
28 (A) establishes alternative or discounted rates of payment, (B)
29 offers the insureds certain advantages for selecting the member
30 providers, or (C) withholds from the insureds certain advantages
31 if they choose providers other than the member providers.
32 Organizations regulated as Medicare Select include, but are not
33 limited to, provider groups, hospital marketing plans, and
34 organizations that are formed or operated by insurers or
35 third-party administrators.

36 (c) The commissioner may authorize an issuer to offer a
37 Medicare Select policy or certificate pursuant to this section if
38 the commissioner finds that the issuer has satisfied all of the
39 requirements of this section.

1 (d) A Medicare Select issuer shall not issue a Medicare Select
2 policy or certificate in this state until its plan of operation has
3 been approved by the commissioner.

4 (e) A Medicare Select issuer shall file a proposed plan of
5 operation with the commissioner in a format prescribed by the
6 commissioner. The plan of operation shall contain at least the
7 following information:

8 (1) Evidence that all covered services that are subject to
9 restricted network provisions are available and accessible
10 through network providers, including a demonstration of all of
11 the following:

12 (A) That services can be provided by network providers with
13 reasonable promptness with respect to geographic location, hours
14 of operation, and afterhour care. The hours of operation and
15 availability of afterhour care shall reflect usual practice in the
16 local area. Geographic availability shall reflect the usual travel
17 times within the community.

18 (B) That the number of network providers in the service area
19 is sufficient, with respect to current and expected policyholders,
20 as to either of the following:

21 (i) To deliver adequately all services that are subject to a
22 restricted network provision.

23 (ii) To make appropriate referrals.

24 (C) There are written agreements with network providers
25 describing specific responsibilities.

26 (D) Emergency care is available 24 hours per day and seven
27 days per week.

28 (E) In the case of covered services that are subject to a
29 restricted network provision and are provided on a prepaid basis,
30 that there are written agreements with network providers
31 prohibiting the providers from billing or otherwise seeking
32 reimbursement from or recourse against any individual insured
33 under a Medicare Select policy or certificate.

34 This subparagraph shall not apply to supplemental charges or
35 coinsurance amounts as stated in the Medicare Select policy or
36 certificate.

37 (2) A statement or map providing a clear description of the
38 service area.

39 (3) A description of the appeal or grievance procedure to be
40 utilized.

1 (4) A description of the quality assurance program, including
2 all of the following:

3 (A) The formal organizational structure.

4 (B) The written criteria for selection, retention, and removal of
5 network providers.

6 (C) The procedures for evaluating quality of care provided by
7 network providers, and the process to initiate corrective action
8 when warranted.

9 (5) A list and description, by specialty, of the network
10 providers.

11 (6) Copies of the written information proposed to be used by
12 the issuer to comply with subdivision (i).

13 (7) Any other information requested by the commissioner.

14 (f) (1) A Medicare Select issuer shall file any proposed
15 changes to the plan of operation, except for changes to the list of
16 network providers, with the commissioner prior to implementing
17 the changes. Changes shall be considered approved by the
18 commissioner after 30 days unless specifically disapproved.

19 (2) An updated list of network providers shall be filed at the
20 commissioner's request, but at least quarterly.

21 (g) A Medicare Select policy or certificate shall not restrict
22 payment for covered services provided by nonnetwork providers
23 if:

24 (1) The services are for symptoms requiring emergency care
25 or are immediately required for an unforeseen illness, injury, or
26 condition.

27 (2) It is not reasonable to obtain services through a network
28 provider.

29 (h) A Medicare Select policy or certificate shall provide
30 payment for full coverage under the policy for covered services
31 that are not available through network providers.

32 (i) A Medicare Select issuer shall make full and fair disclosure
33 in writing of the provisions, restrictions, and limitations of the
34 Medicare Select policy or certificate to each applicant. This
35 disclosure shall include at least the following:

36 (1) An outline of coverage sufficient to permit the applicant to
37 compare the coverage and premiums of the Medicare Select
38 policy or certificate with both of the following:

39 (A) Other Medicare supplement policies or certificates offered
40 by the issuer.

1 (B) Other Medicare Select policies or certificates.

2 (2) A description, including address, telephone number, and
3 hours of operation, of the network providers, including primary
4 care physicians, specialty physicians, hospitals, and other
5 providers.

6 (3) A description of the restricted network provisions,
7 including payments for coinsurance and deductibles when
8 providers other than network providers are utilized. The
9 description shall inform the applicant that expenses incurred
10 when using out-of-network providers are excluded from the
11 out-of-pocket annual limit in benefit plans K and L, unless the
12 policy or certificate provides otherwise.

13 (4) A description of coverage for emergency and urgently
14 needed care and other out-of-service area coverage.

15 (5) A description of limitations on referrals to restricted
16 network providers and to other providers.

17 (6) A description of the policyholder's or certificate holder's
18 rights to purchase any other Medicare supplement policy or
19 certificate otherwise offered by the issuer.

20 (7) A description of the Medicare Select issuer's quality
21 assurance, grievance, and appeal procedure.

22 (j) Prior to the sale of a Medicare Select policy or certificate, a
23 Medicare Select issuer shall obtain from the applicant a signed
24 and dated form stating that the applicant has received the
25 information provided pursuant to subdivision (i) and that the
26 applicant understands the restrictions of the Medicare Select
27 policy or certificate. Acknowledgments shall be maintained by
28 the insurer for at least five years in accordance with Section
29 10508.

30 (k) A Medicare Select issuer shall have and use procedures for
31 hearing complaints and resolving written appeals and grievances
32 from the insureds. The procedures shall be aimed at mutual
33 agreement for settlement and may include arbitration procedures.

34 (1) The appeal and grievance procedure shall be described in
35 the policy and certificates and in the outline of coverage.

36 (2) At the time the policy or certificate is issued, the issuer
37 shall provide detailed information to the policyholder or
38 certificate holder describing how an appeal or grievance may be
39 registered with the issuer.

1 (3) Appeals or grievances shall be considered in a timely
2 manner and shall be transmitted to appropriate fiduciaries who
3 have authority to fully investigate the issue and take corrective
4 action.

5 (4) If an appeal or grievance is found to be valid, corrective
6 action shall be taken promptly.

7 (5) All concerned parties shall be notified about the results of
8 an appeal or grievance.

9 (6) The issuer shall report no later than each March 31st to the
10 commissioner regarding its appeal or grievance procedure. The
11 report shall be in a format prescribed by the commissioner and
12 shall contain the number of appeals or grievances filed in the past
13 year and a summary of the subject, nature, and resolution of
14 those appeals or grievances.

15 (7) Detailed information describing in writing how to register
16 an appeal or grievance shall be provided to the insured prior to,
17 or simultaneously with, the issuance of the policy or certificate.

18 (8) The issuer shall maintain records of each appeal or
19 grievance for at least five years.

20 (l) At the time of initial purchase, a Medicare Select issuer
21 shall make available to each applicant for a Medicare Select
22 policy or certificate the opportunity to purchase any Medicare
23 supplement policy or certificate otherwise offered by the issuer.

24 (m) (1) At the request of an individual insured under a
25 Medicare Select policy or certificate, a Medicare Select issuer
26 shall make available to the individual insured the opportunity to
27 purchase a Medicare supplement policy or certificate offered by
28 the issuer that has comparable or lesser benefits and that does not
29 contain a restricted network provision. The issuer shall make the
30 policies or certificates available without requiring evidence of
31 insurability after the Medicare Select policy or certificate has
32 been in force for six months, unless the replacement policy or
33 certificate includes at-home recovery benefits that were not
34 included in the Medicare Select coverage.

35 (2) For the purposes of this subdivision, a Medicare
36 supplement policy or certificate will be considered to have
37 comparable or lesser benefits unless it contains one or more
38 significant benefits not included in the Medicare Select policy or
39 certificate being replaced. For the purposes of this paragraph, a
40 significant benefit means coverage for the Medicare Part A

1 deductible, coverage for at-home recovery services, or coverage
2 for Medicare Part B excess charges.

3 (n) Medicare Select policies and certificates shall provide for
4 continuation of coverage in the event the commissioner
5 determines that Medicare Select policies and certificates issued
6 pursuant to this section should be discontinued due to either the
7 failure of the Medicare Select program to be reauthorized under
8 law or its substantial amendment.

9 (1) Each Medicare Select issuer shall make available to each
10 individual insured under a Medicare Select policy or certificate
11 the opportunity to purchase any Medicare supplement policy or
12 certificate offered by the issuer that has comparable or lesser
13 benefits and that does not contain a restricted network provision.
14 The issuer shall make the policies and certificates available
15 without requiring evidence of insurability.

16 (2) For the purposes of this subdivision, a Medicare
17 supplement policy or certificate will be considered to have
18 comparable or lesser benefits unless it contains one or more
19 significant benefits not included in the Medicare Select policy or
20 certificate being replaced. For the purposes of this paragraph, a
21 significant benefit means coverage for the Medicare Part A
22 deductible, coverage for at-home recovery services, or coverage
23 for Medicare Part B excess charges.

24 (o) A Medicare Select issuer shall comply with reasonable
25 requests for data made by state or federal agencies, including the
26 United States Department of Health and Human Services for the
27 purpose of evaluating the Medicare Select program.

28 (p) The commissioner may grant special Medicare Select
29 status to plans of guaranteed renewable Medicare supplement
30 coverage provided through a preferred provider organization,
31 which plans were offered to the public or in force before the
32 effective date of this section, if the commissioner determines that
33 the applicants will receive benefits and consumer protections that
34 are substantially equivalent to those in other Medicare Select
35 plans identified in this section, and if the issuer satisfies the
36 following requirements:

37 (1) The issuer shall apply within one year of the effective date
38 of this section by submitting to the commissioner the following
39 items:

40 (A) The current plan of operation as defined in subdivision (e).

(B) If the written disclosures of subdivision (i) have not been delivered to each applicant as required, the issuer's plan to accomplish full disclosure to every insured and to achieve substantial compliance with subdivision (j).

(C) The issuer's statement of intent to comply with subdivision (f).

(D) If the plan of operation does not comply with the standards of subdivision (g), (h), (k), (l), or (m), the issuer's plan for achieving substantial compliance with these subdivisions for every insured.

(2) The issuer shall alter the plan as requested by the commissioner in order to bring the plan into substantial compliance with Medicare Select standards.

(3) The issuer shall issue disclosures or other notices to its insureds regarding its status as Medicare Select as ordered by the commissioner.

(4) The issuer shall provide data as provided in subdivision (o).

~~SEC. 22.—~~

SEC. 23. Section 10192.11 of the Insurance Code is amended to read:

10192.11. (a) (l) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is *both 65 years of age or older and is* enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision *and who are 65 years of age or older.* ~~This~~

(2) *An issuer shall make available Medicare supplement benefit plans A, B, C, and F, if currently available, to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants, Medicare supplement benefit plan H, I, or J, if currently*

1 available, and commencing January 1, 2007, shall make
2 available to them Medicare supplement benefit plan K or L, if
3 currently available. The selection among Medicare supplement
4 plan H, I, or J and the selection between Medicare supplement
5 benefit plan K or L shall be made at the issuer's discretion.

6 (3) This section and Section 10192.12 do not prohibit an issuer
7 in determining premium rates from treating applicants who are
8 under 65 years of age and are eligible for Medicare Part B as a
9 separate risk classification. This section shall not be construed as
10 preventing the exclusion of benefits for preexisting conditions as
11 defined in paragraph (1) of subdivision (a) of Section 10192.8.

12 (b) (1) If an applicant qualifies under subdivision (a) and
13 submits an application during the time period referenced in
14 subdivision (a) and, as of the date of application, has had a
15 continuous period of creditable coverage of at least six months,
16 the issuer shall not exclude benefits based on a preexisting
17 condition.

18 (2) If the applicant qualifies under subdivision (a) and submits
19 an application during the time period referenced in subdivision
20 (a) and, as of the date of application, has had a continuous period
21 of creditable coverage that is less than six months, the issuer
22 shall reduce the period of any preexisting condition exclusion by
23 the aggregate of the period of creditable coverage applicable to
24 the applicant as of the enrollment date. The manner of the
25 reduction under this subdivision shall be as specified by the
26 commissioner.

27 (c) Except as provided in subdivision (b) and Section
28 10192.23, subdivision (a) shall not be construed as preventing the
29 exclusion of benefits under a policy, during the first six months,
30 based on a preexisting condition for which the policyholder or
31 certificate holder received treatment or was otherwise diagnosed
32 during the six months before the coverage became effective.

33 (d) Every issuer shall make available to every applicant
34 qualified for open enrollment all policies and certificates offered
35 by that issuer at the time of application. Issuers shall not
36 discourage sales during the open enrollment period by any
37 means, including the altering of the commission structure.

38 (e) (1) An individual enrolled in Medicare Part B is entitled to
39 open enrollment described in this section for six months
40 following:

1 (A) Receipt of a notice of termination or, if no notice is
2 received, the effective date of termination from any
3 employer-sponsored health plan including an
4 employer-sponsored retiree health plan.

5 (B) Receipt of a notice of loss of eligibility due to the divorce
6 or death of a spouse or, if no notice is received, the effective date
7 of loss of eligibility due to the divorce or death of a spouse, from
8 any employer-sponsored health plan including an
9 employer-sponsored retiree health plan.

10 (C) Termination of health care services for a military retiree or
11 the retiree's Medicare eligible spouse or dependent as a result of
12 a military base closure or loss of access to health care services
13 because the base no longer offers services or because the
14 individual relocates.

15 (2) For purposes of this subdivision, "employer-sponsored
16 retiree health plan" includes any coverage for medical expenses
17 that is directly or indirectly sponsored or established by an
18 employer for employees or retirees, their spouses, dependents, or
19 other included insureds.

20 (f) An individual enrolled in Medicare Part B is entitled to
21 open enrollment described in this section if the individual was
22 covered under a policy, certificate, or contract providing
23 Medicare supplement coverage but that coverage terminated
24 because the individual established residence at a location not
25 served by the plan.

26 (g) An individual whose coverage was terminated by a
27 Medicare Advantage plan shall be entitled to an additional
28 60-day open enrollment period to be added on to and run
29 consecutively after any open enrollment period authorized by
30 federal law or regulation, for any Medicare supplement coverage
31 provided by Medicare supplement issuers and available on a
32 guaranteed basis under state and federal law or regulation for
33 persons terminated by their Medicare Advantage plan.

34 (h) An individual shall be entitled to an annual open
35 enrollment period lasting 30 days or more, commencing with the
36 individual's birthday, during which time that person may
37 purchase any Medicare supplement policy that offers benefits
38 equal to or lesser than those provided by the previous coverage.
39 During this open enrollment period, no issuer that falls under this
40 provision shall deny or condition the issuance or effectiveness of

1 Medicare supplement coverage, nor discriminate in the pricing of
2 coverage, because of health status, claims experience, receipt of
3 health care, or medical condition of the individual if, at the time
4 of the open enrollment period, the individual is covered under
5 another Medicare supplement policy or contract. An issuer shall
6 notify a policyholder of his or her rights under this subdivision at
7 least 30 and no more than 60 days before the beginning of the
8 open enrollment period.

9 (i) ~~An~~ Commencing January 1, 2007, an individual enrolled in
10 Medicare Part B is entitled to open enrollment described in this
11 section upon being notified that he or she is no longer eligible for
12 benefits under the Medi-Cal program *because of an increase in*
13 *the individual's income or assets.*

14 ~~SEC. 23.—~~

15 ~~SEC. 24.~~ Section 10192.12 of the Insurance Code is repealed.

16 ~~SEC. 24.—~~

17 ~~SEC. 25.~~ Section 10192.12 is added to the Insurance Code, to
18 read:

19 10192.12. (a) (1) With respect to the guaranteed issue of a
20 Medicare supplement policy, eligible persons are those
21 individuals described in subdivision (b) who seek to enroll under
22 the policy during the period specified in subdivision (c), and who
23 submit evidence of the date of termination or disenrollment or
24 enrollment in Medicare Part D with the application for a
25 Medicare supplement policy.

26 (2) With respect to eligible persons, an issuer shall not take
27 any of the following actions:

28 (A) Deny or condition the issuance or effectiveness of a
29 Medicare supplement policy described in subdivision (e) that is
30 offered and is available for issuance to new enrollees by the
31 issuer.

32 (B) Discriminate in the pricing of that Medicare supplement
33 policy because of health status, claims experience, receipt of
34 health care, or medical condition.

35 (C) Impose an exclusion of benefits based on a preexisting
36 condition under that Medicare supplement policy.

37 (b) An eligible person is an individual described in any of the
38 following paragraphs:

39 (1) The individual is enrolled under an employee welfare
40 benefit plan that provides health benefits that supplement the

benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply:

(A) The certification of the organization or plan has been terminated.

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary. Those changes in circumstances shall not include termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area.

(D) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible under this subparagraph for a Medicare supplement policy issued by the same issuer through which the individual was enrolled at the time of the reduction, increase, or discontinuance described above occurs or, *commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer.* ~~If no Medicare supplement policy is available from that issuer, the individual shall be eligible for standardized Medicare benefit plans A, B, C, and F (including standardized Medicare supplement high deductible plan F), K, or L from any issuer of one of these plans.~~

(E) The individual demonstrates, in accordance with guidelines established by the secretary, either of the following:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this article

1 in relation to the individual, including the failure to provide on a
2 timely basis medically necessary care for which benefits are
3 available under the plan or the failure to provide the covered care
4 in accordance with applicable quality standards.

5 (ii) The organization, or agent or other entity acting on the
6 organization's behalf, materially misrepresented the plan's
7 provisions in marketing the plan to the individual.

8 (F) The individual meets other exceptional conditions as the
9 secretary may provide.

10 (3) The individual is 65 years of age or older, is enrolled with
11 a Program of All-Inclusive Care for the Elderly (PACE) provider
12 under Section 1894 of the Social Security Act, and circumstances
13 similar to those described in paragraph (2) exist that would
14 permit discontinuance of the individual's enrollment with the
15 provider, if the individual were enrolled in a Medicare
16 Advantage plan.

17 (4) The individual meets both of the following conditions:

18 (A) The individual is enrolled with any of the following:

19 (i) An eligible organization under a contract under Section
20 1876 of the Social Security Act (Medicare cost).

21 (ii) A similar organization operating under demonstration
22 project authority, effective for periods before April 1, 1999.

23 (iii) An organization under an agreement under Section
24 1833(a)(1)(A) of the Social Security Act (health care prepayment
25 plan).

26 (iv) An organization under a Medicare Select policy.

27 (B) The enrollment ceases under the same circumstances that
28 would permit discontinuance of an individual's election of
29 coverage under paragraph (2) or (3).

30 (5) The individual is enrolled under a Medicare supplement
31 policy, and the enrollment ceases because of any of the following
32 circumstances:

33 (A) The insolvency of the issuer or bankruptcy of the
34 nonissuer organization, or other involuntary termination of
35 coverage or enrollment under the policy.

36 (B) The issuer of the policy substantially violated a material
37 provision of the policy.

38 (C) The issuer, or an agent or other entity acting on the
39 issuer's behalf, materially misrepresented the policy's provisions
40 in marketing the policy to the individual.

(6) The individual meets both of the following conditions:

(A) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy.

(B) The subsequent enrollment under subparagraph (A) is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act).

(7) The individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

(8) The individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy described in ~~subparagraph (B) of paragraph (2) of subdivision (c)~~. *paragraph (4) of subdivision (e)*.

(c) (1) In the case of an individual described in paragraph (1) of subdivision (b), the guaranteed issue period begins on the later of the following two dates and ends on the date that is 63 days after the date the applicable coverage terminates:

(A) The date the individual receives a notice of termination or cessation of all supplemental health benefits or, if no notice is received, the date of the notice denying a claim because of a termination or cessation of benefits.

(B) The date that the applicable coverage terminates or ceases.

(2) In the case of an individual described in paragraphs (2), (3), (4), (6), and (7) of subdivision (b) whose enrollment is

1 terminated involuntarily, the guaranteed issue period begins on
2 the date that the individual receives a notice of termination and
3 ends 63 days after the date the applicable coverage is terminated.

4 (3) In the case of an individual described in subparagraph (A)
5 of paragraph (5) of subdivision (b), the guaranteed issue period
6 begins on the earlier of the following two dates and ends on the
7 date that is 63 days after the date the coverage is terminated:

8 (A) The date that the individual receives a notice of
9 termination, a notice of the issuer's bankruptcy or insolvency, or
10 other similar notice if any.

11 (B) The date that the applicable coverage is terminated.

12 (4) In the case of an individual described in paragraph (2), (3),
13 (6), or (7) of, or in subparagraph (B) or (C) of paragraph (5) of,
14 subdivision (b) who disenrolls voluntarily, the guaranteed issue
15 period begins on the date that is 60 days before the effective date
16 of the disenrollment and ends on the date that is 63 days after the
17 effective date of the disenrollment.

18 (5) In the case of an individual described in paragraph (8) of
19 subdivision (b), the guaranteed issue period begins on the date
20 the individual receives notice pursuant to Section 1882(v)(2)(B)
21 of the Social Security Act from the Medicare supplement issuer
22 during the 60-day period immediately preceding the initial
23 enrollment period for Medicare Part D and ends on the date that
24 is 63 days after the effective date of the individual's coverage
25 under Medicare Part D.

26 (6) In the case of an individual described in subdivision (b)
27 who is not included in this subdivision, the guaranteed issue
28 period begins on the effective date of disenrollment and ends on
29 the date that is 63 days after the effective date of disenrollment.

30 (d) (1) In the case of an individual described in paragraph (6)
31 of subdivision (b), or deemed to be so described pursuant to this
32 paragraph, whose enrollment with an organization or provider
33 described in subparagraph (A) of paragraph (6) of subdivision (b)
34 is involuntarily terminated within the first 12 months of
35 enrollment and who, without an intervening enrollment, enrolls
36 with another such organization or provider, the subsequent
37 enrollment shall be deemed to be an initial enrollment described
38 in paragraph (6) of subdivision (b).

39 (2) In the case of an individual described in paragraph (7) of
40 subdivision (b), or deemed to be so described pursuant to this

paragraph, whose enrollment with a plan or in a program described in paragraph (7) of subdivision (b) is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph (7) of subdivision (b).

(3) For purposes of paragraphs (6) and (7) of subdivision (b), an enrollment of an individual with an organization or provider described in subparagraph (A) of paragraph (6) of subdivision (b), or with a plan or in a program described in paragraph (7) of subdivision (b) shall not be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

(e) (1) Under paragraphs (1), (2), (3), (4), and (5) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(2) (A) Under paragraph (6) of subdivision (b), an eligible individual is entitled to the same Medicare supplement policy in which he or she was most recently enrolled, if available from the same issuer. If that policy is not available, the eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high deductible Plan F), K, or L offered by any issuer.

(B) On and after January 1, 2006, an eligible individual described in this paragraph who was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, is entitled to a Medicare supplement policy that is available from the same issuer but without an outpatient prescription drug benefit or, at the election of the individual, has a benefit package classified as a Plan A, B, C, F (including high deductible Plan F), K, or L that is offered by any issuer.

(3) Under paragraph (7) of subdivision (b), an eligible individual is entitled to any Medicare supplement policy offered by any issuer.

(4) Under paragraph (8) of subdivision (b), an eligible individual is entitled to a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including a high

1 *deductible Plan F), K, or L and that is offered and is available*
2 *for issuance to a new enrollee by the same issuer that issued the*
3 *individual's Medicare supplement policy with outpatient*
4 *prescription drug coverage.*

5 (f) (1) At the time of an event described in subdivision (b) by
6 which an individual loses coverage or benefits due to the
7 termination of a contract or agreement, policy, or plan, the
8 organization that terminates the contract or agreement, the issuer
9 terminating the policy, or the administrator of the plan being
10 terminated, respectively, shall notify the individual of his or her
11 rights under this section and of the obligations of issuers of
12 Medicare supplement policies under subdivision (a). The notice
13 shall be communicated contemporaneously with the notification
14 of termination.

15 (2) At the time of an event described in subdivision (b) by
16 which an individual ceases enrollment under a contract or
17 agreement, policy, or plan, the organization that offers the
18 contract or agreement, regardless of the basis for the cessation of
19 enrollment, the issuer offering the policy, or the administrator of
20 the plan, respectively, shall notify the individual of his or her
21 rights under this section, and of the obligations of issuers of
22 Medicare supplement policies under subdivision (a). The notice
23 shall be communicated within 10 working days of the date the
24 issuer received notification of disenrollment.

25 (g) An issuer shall refund any unearned premium that an
26 insured paid in advance and shall terminate coverage upon the
27 request of an insured.

28 ~~SEC. 25.—~~

29 *SEC. 26.* Section 10192.14 of the Insurance Code is amended
30 to read:

31 10192.14. (a) (1) (A) With respect to loss ratio standards, a
32 Medicare supplement policy form or certificate form shall not be
33 advertised, solicited, or issued for delivery unless the policy form
34 or certificate form can be expected, as estimated for the entire
35 period for which rates are computed to provide coverage, to
36 return to policyholders and certificate holders in the form of
37 aggregate benefits, not including anticipated refunds or credits,
38 provided under the policy form or certificate form at least 75
39 percent of the aggregate amount of premiums earned in the case

1 of group policies, or at least 65 percent of the aggregate amount
2 of premiums earned in the case of individual policies.

3 (B) Loss ratio standards shall be calculated on the basis of
4 incurred claims experience, and earned premiums shall be
5 calculated for the period and in accordance with accepted
6 actuarial principles and practices.

7 (2) All filings of rates and rating schedules shall demonstrate
8 that expected claims in relation to premiums comply with the
9 requirements of this section when combined with actual
10 experience to date. Filings of rate revisions shall also
11 demonstrate that the anticipated loss ratio over the entire future
12 period for which the revised rates are computed to provide
13 coverage can be expected to meet the appropriate loss ratio
14 standards.

15 (3) For purposes of applying paragraph (1) of subdivision (a)
16 and paragraph (3) of subdivision (d) of Section 10192.15 only,
17 policies issued as a result of solicitations of individuals through
18 the mail or by mass media advertising, including both print and
19 broadcast advertising, shall be deemed to be individual policies.

20 (b) (1) With respect to refund or credit calculations, an issuer
21 shall collect and file with the commissioner by May 31 of each
22 year the data contained in the applicable reporting form required
23 by the commissioner for each type of coverage in a standard
24 Medicare supplement benefit plan.

25 (2) If on the basis of the experience as reported the benchmark
26 ratio since inception (ratio 1) exceeds the adjusted experience
27 ratio since inception (ratio 3), then a refund or credit calculation
28 is required. The refund calculation shall be done on a statewide
29 basis for each type in a standard Medicare supplement benefit
30 plan. For purposes of the refund or credit calculation, experience
31 on policies issued within the reporting year shall be excluded.

32 (3) For the purposes of this section, with respect to policies or
33 certificates advertised, solicited, or issued for delivery prior to
34 January 1, 2001, the issuer shall make the refund or credit
35 calculation separately for all individual policies, including all
36 group policies subject to an individual loss ratio standard when
37 issued, combined and all other group policies combined for
38 experience after January 1, 2001. The first report pursuant to
39 paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement policies and certificates shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner and this code. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates shall file with the commissioner, in accordance with applicable filing procedures, all of the following:

(1) (A) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(B) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy other

1 than the adjustments described in this section shall be made with
2 respect to a policy at any time other than upon its renewal date or
3 anniversary date.

4 (C) If an issuer fails to make premium adjustments acceptable
5 to the commissioner, the commissioner may order premium
6 adjustments, refunds, or premium credits deemed necessary to
7 achieve the loss ratio required by this section.

8 (2) Any appropriate riders, endorsements, or policy forms
9 needed to accomplish the Medicare supplement policy or
10 certificate modifications necessary to eliminate benefit
11 duplications with Medicare. The riders, endorsements, or policy
12 forms shall provide a clear description of the Medicare
13 supplement benefits provided by the policy or certificate.

14 (d) The commissioner may conduct a public hearing to gather
15 information concerning a request by an issuer for an increase in a
16 rate for a policy form or certificate form issued before or after the
17 effective date of January 1, 2001, if the experience of the form
18 for the previous reporting period is not in compliance with the
19 applicable loss ratio standard. The determination of compliance
20 is made without consideration of any refund or credit for the
21 reporting period. Public notice of the hearing shall be furnished
22 in a manner deemed appropriate by the commissioner.

23 ~~SEC. 26.—~~

24 *SEC. 27.* Section 10192.15 of the Insurance Code is amended
25 to read:

26 10192.15. (a) An issuer shall not advertise, solicit, or issue
27 for delivery a policy or certificate to a resident of this state unless
28 the policy form or certificate form has been filed with and
29 approved by the commissioner in accordance with filing
30 requirements and procedures prescribed by the commissioner.
31 Master policies issued outside California shall be filed for
32 informational purposes along with the certificates. Until January
33 1, 2001, or 90 days after approval of Medicare supplement
34 policies or certificates submitted for approval pursuant to this
35 section, whichever is later, issuers may continue to offer and
36 market previously approved Medicare supplement policies or
37 certificates.

38 (b) An issuer shall file any riders or amendments to policy or
39 certificate forms to delete outpatient prescription drug benefits,
40 as required by the Medicare Prescription Drug, Improvement,

1 and Modernization Act of 2003 (P.L. 108-173), only with the
2 commissioner in the state where the policy or certificate was
3 issued.

4 (c) (1) An issuer shall not use or change premium rates for a
5 Medicare supplement policy or certificate unless the rates, rating
6 schedule, and supporting documentation have been filed with and
7 approved by the commissioner in accordance with the filing
8 requirements and procedures prescribed by the commissioner.

9 (2) Paragraph (1) of subdivision (b) of Section 10290 shall not
10 apply to Medicare supplement insurance forms or rates.
11 However, the commissioner may authorize in writing, for good
12 cause only, the limited use of a form or rates after that form or
13 the rates have been filed with the commissioner for 60 days and
14 have not otherwise been acted upon.

15 (d) (1) Except as provided in paragraph (2), an issuer shall not
16 file for approval more than one form of a policy or certificate of
17 each type for each standard Medicare supplement benefit plan.

18 (2) An issuer may offer, with the approval of the
19 commissioner, up to four additional policy forms or certificate
20 forms of the same type for the same standard Medicare
21 supplement benefit plan, one for each of the following cases:

22 (A) The inclusion of new or innovative benefits.

23 (B) The addition of either direct response or agent marketing
24 methods.

25 (C) The addition of either guaranteed issue or underwritten
26 coverage.

27 (D) The offering of coverage to individuals eligible for
28 Medicare by reason of disability.

29 (3) For the purposes of this section, a “type” means an
30 individual policy, a group policy, an individual Medicare Select
31 policy, or a group Medicare Select policy.

32 (e) (1) Except as provided in subdivision (a), an issuer shall
33 continue to make available for purchase any policy form or
34 certificate form issued after January 1, 2001, that has been
35 approved by the commissioner. A policy form or certificate form
36 shall not be considered to be available for purchase unless the
37 issuer has actively offered it for sale in the previous 12 months.

38 (A) An issuer may discontinue the availability of a policy form
39 or certificate form if the issuer provides to the commissioner in
40 writing its decision at least 60 days prior to discontinuing the

1 availability of the form of the policy or certificate. After receipt
2 of the notice by the commissioner, the issuer shall no longer offer
3 for sale the policy form or certificate form in this state.

4 (B) An issuer that discontinues the availability of a policy
5 form or certificate form pursuant to subparagraph (A) shall not
6 file for approval a new policy form or certificate form of the
7 same type for the same standard Medicare supplement benefit
8 plan as the discontinued form for a period of five years after the
9 issuer provides notice to the commissioner of the discontinuance.
10 The period of discontinuance may be reduced if the
11 commissioner determines that a shorter period is appropriate.

12 (2) The sale or other transfer of Medicare supplement business
13 to another issuer shall be considered a discontinuance for the
14 purposes of this subdivision.

15 (3) A change in the rating structure or methodology shall be
16 considered a discontinuance under paragraph (1) unless the issuer
17 complies with the following requirements:

18 (A) The issuer provides an actuarial memorandum, in a form
19 and manner prescribed by the commissioner, describing the
20 manner in which the revised rating methodology and resultant
21 rates differ from the existing rating methodology and existing
22 rates. The commissioner may approve the change if it is in the
23 public interest.

24 (B) The issuer does not subsequently put into effect a change
25 of rates or rating factors that would cause the percentage
26 differential between the discontinued and subsequent rates as
27 described in the actuarial memorandum to change. The
28 commissioner may approve a change to the differential that is in
29 the public interest. The commissioner may approve a change to
30 the differential if it is in the public interest.

31 (f) (1) Except as provided in paragraph (2), the experience of
32 all policy forms or certificate forms of the same type in a
33 standard Medicare supplement benefit plan shall be combined for
34 purposes of the refund or credit calculation prescribed in Section
35 10192.14.

36 (2) Forms assumed under an assumption reinsurance
37 agreement shall not be combined with the experience of other
38 forms for purposes of the refund or credit calculation.

1 ~~SEC. 27.—~~

2 *SEC. 28.* Section 10192.17 of the Insurance Code is amended
3 to read:

4 10192.17. (a) Medicare supplement policies and certificates
5 shall include a renewal, continuation, or conversion provision.
6 The language or specifications of the provision shall be
7 consistent with the type of contract issued. The provision shall be
8 appropriately captioned and shall appear on the first page of the
9 policy, and shall include any reservation by the issuer of the right
10 to change premiums and any automatic renewal premium
11 increases based on the policyholder's age.

12 (b) Except for riders or endorsements by which the issuer
13 effectuates a request made in writing by the insured, exercises a
14 specifically reserved right under a Medicare supplement policy,
15 or is required to reduce or eliminate benefits to avoid duplication
16 of Medicare benefits, all riders or endorsements added to a
17 Medicare supplement policy after the date of issue or upon
18 reinstatement or renewal that reduce or eliminate benefits or
19 coverage in the policy shall require a signed acceptance by the
20 insured. After the date of policy or certificate issue, any rider or
21 endorsement that increases benefits or coverage with a
22 concomitant increase in premium during the policy term shall be
23 agreed to in writing signed by the insured, unless the benefits are
24 required by the minimum standards for Medicare supplement
25 policies, or if the increased benefits or coverage is required by
26 law. If a separate additional premium is charged for benefits
27 provided in connection with riders or endorsements, the premium
28 charge shall be set forth in the policy.

29 (c) Medicare supplement policies or certificates shall not
30 provide for the payment of benefits based on standards described
31 as "usual and customary," "reasonable and customary," or words
32 of similar import.

33 (d) If a Medicare supplement policy or certificate contains any
34 limitations with respect to preexisting conditions, those
35 limitations shall appear as a separate paragraph of the policy and
36 be labeled as "Preexisting Condition Limitations."

37 (e) (1) Medicare supplement policies and certificates shall
38 have a notice prominently printed on the first page of the policy
39 or certificate, and of the outline of coverage, or attached thereto,
40 in no less than 10-point uppercase type, stating in substance that

the policyholder or certificate holder shall have the right to return the policy or certificate, via regular mail, within 30 days of receiving it, and to have the full premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. The return shall void the contract from the beginning, and the parties shall be in the same position as if no contract had been issued.

(2) For purposes of this section, a timely manner shall be no later than 30 days after the issuer receives the returned contract.

(3) If the issuer fails to refund all prepaid or periodic charges paid in a timely manner, then the applicant shall receive interest on the paid charges at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the issuer received the returned contract.

(f) (1) Issuers of health insurance policies, certificates, or contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued for delivery as Medicare supplement policies or certificates as defined in this article. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request, but not later than at the time the policy is delivered.

(2) For the purposes of this section, “form” means the language, format, type size, type proportional spacing, bold character, and line spacing.

(g) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement policies or

1 certificates in a format acceptable to the commissioner. The
2 notice shall include both of the following:

3 (1) A description of revisions to the Medicare Program and a
4 description of each modification made to the coverage provided
5 under the Medicare supplement policy or certificate.

6 (2) Inform each policyholder or certificate holder as to when
7 any premium adjustment is to be made due to changes in
8 Medicare.

9 (h) The notice of benefit modifications and any premium
10 adjustments shall be in outline form and in clear and simple
11 terms so as to facilitate comprehension.

12 (i) The notices shall not contain or be accompanied by any
13 solicitation.

14 (j) (1) Issuers shall provide an outline of coverage to all
15 applicants at the time application is presented to the prospective
16 applicant and, except for direct response policies, shall obtain an
17 acknowledgment of receipt of the outline from the applicant. If
18 an outline of coverage is provided at the time of application and
19 the Medicare supplement policy or certificate is issued on a basis
20 which would require revision of the outline, a substitute outline
21 of coverage properly describing the policy or certificate shall
22 accompany the policy or certificate when it is delivered and
23 contain the following statement, in no less than 12-point type,
24 immediately above the company name:

25
26 “NOTICE: Read this outline of coverage carefully. It is not
27 identical to the outline of coverage provided upon application
28 and the coverage originally applied for has not been issued.”
29

30 (2) The outline of coverage provided to applicants pursuant to
31 this section consists of four parts: a cover page, premium
32 information, disclosure pages, and charts displaying the features
33 of each benefit plan offered by the issuer. The outline of
34 coverage shall be in the language and format prescribed below in
35 no less than 12-point type. All plans A-L shall be shown on the
36 cover page, and the plans that are offered by the issuer shall be
37 prominently identified. Premium information for plans that are
38 offered shall be shown on the cover page or immediately
39 following the cover page and shall be prominently displayed. The
40 premium and mode shall be stated for all plans that are offered to

1 the prospective applicant. All possible premiums for the
2 prospective applicant shall be illustrated.

3 (3) The commissioner may adopt regulations to implement this
4 article, including, but not limited to, regulations that specify the
5 required information to be contained in the outline of coverage
6 provided to applicants pursuant to this section, including the
7 format of tables, charts, and other information.

8 (k) (1) Any disability insurance policy or certificate, a basic,
9 catastrophic or major medical expense policy, or single premium
10 nonrenewal policy or certificate issued to persons eligible for
11 Medicare, other than a Medicare supplement policy, a policy
12 issued pursuant to a contract under Section 1876 of the federal
13 Social Security Act (42 U.S.C. Sec. 1395 et seq.), a disability
14 income policy, or any other policy identified in subdivision (b) of
15 Section 10192.3, advertised, solicited, or issued for delivery in
16 this state to persons eligible for Medicare, shall notify insureds
17 under the policy that the policy is not a Medicare supplement
18 policy or certificate. The notice shall either be printed or attached
19 to the first page of the outline of coverage delivered to insureds
20 under the policy, or if no outline of coverage is delivered, to the
21 first page of the policy or certificate delivered to insureds. The
22 notice shall be in no less than 12-point type and shall contain the
23 following language:

24
25 “THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE
26 SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible
27 for Medicare, review the Guide to Health Insurance for People
28 with Medicare available from the company.”
29

30 (2) Applications provided to persons eligible for Medicare for
31 the disability insurance policies or certificates described in
32 paragraph (1) shall disclose the extent to which the policy
33 duplicates Medicare in a manner required by the commissioner.
34 The disclosure statement shall be provided as a part of, or
35 together with, the application for the policy or certificate.

36 (l) (1) Insurers issuing Medicare supplement policies or
37 certificates for delivery in California shall provide an outline of
38 coverage to all applicants at the time of presentation for
39 examination or sale as provided in Section 10605, and in no case
40 later than at the time the application is made. Except for direct

1 response policies, insurers shall obtain a written acknowledgment
2 of receipt of the outline from the applicant.

3 Any advertisement that is not a presentation for examination or
4 sale as defined in subdivision (e) of Section 10601 shall contain
5 a notice in no less than 10-point uppercase type that an outline of
6 coverage is available upon request. The insurer or agent that
7 receives any request for an outline of coverage shall provide an
8 outline of coverage to the person making the request within 14
9 days of receipt of the request.

10 (2) If an outline of coverage is provided at or before the time
11 of application and the Medicare supplement policy or certificate
12 is issued on a basis that would require revision of the outline, a
13 substitute outline of coverage properly describing the policy or
14 certificate shall accompany the policy or certificate when it is
15 delivered and contain the following statement, in no less than
16 12-point type, immediately above the name:

17
18 “NOTICE: Read this outline of coverage carefully. It is not
19 identical to the outline of coverage provided upon application
20 and the coverage originally applied for has not been issued.”

21
22 (3) The outline of coverage shall be in the language and
23 format prescribed in this subdivision in no less than 12-point
24 type, and shall include the following items in the order prescribed
25 below. Titles, as set forth below in paragraphs (B) to (H),
26 inclusive, shall be capitalized, centered, and printed in boldface
27 type. The outline of coverage shall include the items, and in the
28 same order, specified in the chart set forth in Section 17 of the
29 Model Regulation to implement the NAIC Medicare Supplement
30 Insurance Minimum Standards Model Act, as adopted by the
31 National Association of Insurance Commissioners in 2004.

32 (A) The cover page shall contain the 12-plan (A-L) charts. The
33 plans offered by the insurer shall be clearly identified. Innovative
34 benefits shall be explained in a manner approved by the
35 commissioner. The text shall read:

36
37 “Medicare supplement insurance can be sold in only 12
38 standard plans. This chart shows the benefits included in each
39 plan. Every insurance company must offer Plan A. Some plans
40 may not be available.

1 The BASIC BENEFITS included in ALL plans are:

2 Hospitalization: Medicare Part A coinsurance plus coverage for
3 365 additional days after Medicare benefits end.

4 Medical expenses: Medicare Part B coinsurance (usually 20
5 percent of the Medicare-approved amount).

6 Blood: First three pints of blood each year.

7 Mammogram: One annual screening to the extent not covered
8 by Medicare.

9 Cervical cancer test: One annual screening.”

10
11 [Reference to the mammogram and cervical cancer test shall
12 not be included so long as California is required to disallow them
13 for Medicare beneficiaries by the Centers for Medicare and
14 Medicaid Services or other agent of the federal government
15 under 42 U.S.C. Sec. 1395ss.]

16 (B) PREMIUM INFORMATION. Premium information for
17 plans that are offered by the insurer shall be shown on, or
18 immediately following, the cover page and shall be clearly and
19 prominently displayed. The premium and mode shall be stated
20 for all offered plans. All possible premiums for the prospective
21 applicant shall be illustrated in writing. If the premium is based
22 on the increasing age of the insured, information specifying when
23 and how premiums will change shall be clearly illustrated in
24 writing. The text shall state: “We [the insurer’s name] can only
25 raise your premium if we raise the premium for all policies like
26 yours in California.”

27 (C) The text shall state: “Use this outline to compare benefits
28 and premiums among policies.”

29 (D) READ YOUR POLICY VERY CAREFULLY. The text
30 shall state: “This is only an outline describing your policy’s most
31 important features. The policy is your insurance contract. You
32 must read the policy itself to understand all of the rights and
33 duties of both you and your insurance company.”

34 (E) THIRTY-DAY RIGHT TO RETURN THIS POLICY. The
35 text shall state: “If you find that you are not satisfied with your
36 policy, you may return it to [insert the insurer’s address]. If you
37 send the policy back to us within 30 days after you receive it, we
38 will treat the policy as if it has never been issued and return all of
39 your payments.”

1 (F) POLICY REPLACEMENT. The text shall read: “If you
2 are replacing another health insurance policy, do NOT cancel it
3 until you have actually received your new policy and are sure
4 you want to keep it.”

5 (G) DISCLOSURES. The text shall read: “This policy may
6 not fully cover all of your medical costs.” “Neither this company
7 nor any of its agents are connected with Medicare.” “This outline
8 of coverage does not give all the details of Medicare coverage.
9 Contact your local social security office or consult ‘The
10 Medicare Handbook’ for more details.” “For additional
11 information concerning policy benefits, contact the Health
12 Insurance Counseling and Advocacy Program (HICAP) or your
13 agent. Call the HICAP toll-free telephone number,
14 1-800-434-0222, for a referral to your local HICAP office.
15 HICAP is a service provided free of charge by the State of
16 California.”

17 The disclosure required by this paragraph, as revised by
18 amendments made during the 1996 portion of the 1995-96
19 Regular Session, shall be included in the required disclosure
20 form no later than January 1, 1998.

21 (H) [For policies that are not guaranteed issue] COMPLETE
22 ANSWERS ARE IMPORTANT. The text shall read: “When you
23 fill out the application for a new policy, be sure to answer
24 truthfully and completely all questions about your medical and
25 health history. The company may have the right to cancel your
26 policy and refuse to pay any claims if you leave out or falsify
27 important medical information.

28 Review the application carefully before you sign it. Be certain
29 that all information has been properly recorded.”

30 (I) One chart for each benefit plan offered by the insurer
31 showing the services, Medicare payments, payments under the
32 policy and payments expected from the insured, using the same
33 uniform format and language. No more than four plans may be
34 shown on one page. Include an explanation of any innovative
35 benefits in a manner approved by the commissioner.

36 (m) An issuer shall comply with all notice requirements of the
37 Medicare Prescription Drug, Improvement, and Modernization
38 Act of 2003 (P.L. 108-173).

1 ~~SEC. 28.~~—

2 *SEC. 29.* Section 10192.18 of the Insurance Code is amended
3 to read:

4 10192.18. (a) Application forms shall include the following
5 questions designed to elicit information as to whether, as of the
6 date of the application, the applicant currently has Medicare
7 supplement, Medicare Advantage, Medi-Cal coverage, or another
8 health insurance policy or certificate in force or whether a
9 Medicare supplement policy or certificate is intended to replace
10 any other disability policy or certificate presently in force. A
11 supplementary application or other form to be signed by the
12 applicant and agent containing those questions and statements
13 may be used.

14
15 “(Statements)”
16

17 (1) You do not need more than one Medicare supplement
18 policy.

19 (2) If you purchase this policy, you may want to evaluate your
20 existing health coverage and decide if you need multiple
21 coverages.

22 (3) You may be eligible for benefits under Medi-Cal and may
23 not need a Medicare supplement policy.

24 (4) If after purchasing this policy you become eligible for
25 Medi-Cal, the benefits and premiums under your Medicare
26 supplement policy can be suspended, if requested, during your
27 entitlement to benefits under Medi-Cal for 24 months. You must
28 request this suspension within 90 days of becoming eligible for
29 Medi-Cal. If you are no longer entitled to Medi-Cal, your
30 suspended Medicare supplement policy or if that is no longer
31 available, a substantially equivalent policy, will be reinstituted if
32 requested within 90 days of losing Medi-Cal eligibility. If the
33 Medicare supplement policy provided coverage for outpatient
34 prescription drugs and you enrolled in Medicare Part D while
35 your policy was suspended, the reinstituted policy will not have
36 outpatient prescription drug coverage, but will otherwise be
37 substantially equivalent to your coverage before the date of the
38 suspension.

39 (5) If you are eligible for, and have enrolled in, a Medicare
40 supplement policy by reason of disability and you later become

covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

- 1
- 2 (1) (a) Did you turn 65 years of age in the last 6 months?
- 3 Yes ☐ No ☐
- 4 (b) Did you enroll in Medicare Part B in the last 6 months?
- 5 Yes ☐ No ☐
- 6 (c) If yes, what is the effective date? _____
- 7 (2) Are you covered for medical assistance through
- 8 California's Medi-Cal program?
- 9 NOTE TO APPLICANT: If you have a share of cost under the
- 10 Medi-Cal program, please answer NO to this question.
- 11 Yes ☐ No ☐
- 12 If yes,
- 13 (a) Will Medi-Cal pay your premiums for this Medicare
- 14 supplement policy?
- 15 Yes ☐ No ☐
- 16 (b) Do you receive benefits from Medi-Cal OTHER THAN
- 17 payments toward your Medicare Part B premium?
- 18 Yes ☐ No ☐
- 19 (3) (a) If you had coverage from any Medicare plan other than
- 20 original Medicare within the past 63 days (for example, a
- 21 Medicare Advantage plan or a Medicare HMO or PPO), fill in
- 22 your start and end dates below. If you are still covered under this
- 23 plan, leave "END" blank.
- 24 START / / END / /
- 25 (b) If you are still covered under the Medicare plan, do you
- 26 intend to replace your current coverage with this new Medicare
- 27 supplement policy?
- 28 Yes ☐ No ☐
- 29 (c) Was this your first time in this type of Medicare plan?
- 30 Yes ☐ No ☐
- 31 (d) Did you drop a Medicare supplement policy to enroll in the
- 32 Medicare plan?
- 33 Yes ☐ No ☐
- 34 (4) (a) Do you have another Medicare supplement policy in
- 35 force?
- 36 Yes ☐ No ☐
- 37 (b) If so, with what company, and what plan do you have
- 38 [optional for direct mailers]?
- 39 Yes ☐ No ☐

1 (c) If so, do you intend to replace your current Medicare
2 supplement policy with this policy?

3 Yes _____ No _____

4 (5) Have you had coverage under any other health insurance
5 within the past 63 days? (For example, an employer, union, or
6 individual plan)

7 Yes _____ No _____

8 (a) If so, with what companies and what kind of policy?

9 _____

10 _____

11 _____

12
13 (b) What are your dates of coverage under the other policy?

14 START __/__/__ END __/__/__

15 (If you are still covered under the other policy, leave “END”
16 blank.)

17
18 (b) Agents shall list any other health insurance policies they
19 have sold to the applicant as follows:

20 (1) List policies sold that are still in force.

21 (2) List policies sold in the past five years that are no longer in
22 force.

23 (c) In the case of a direct response issuer, a copy of the
24 application or supplemental form, signed by the applicant, and
25 acknowledged by the issuer, shall be returned to the applicant by
26 the issuer upon delivery of the policy.

27 (d) Upon determining that a sale will involve replacement of
28 Medicare supplement coverage, any issuer, other than a direct
29 response issuer, or its agent, shall furnish the applicant, prior to
30 issuance for delivery of the Medicare supplement policy or
31 certificate, a notice regarding replacement of Medicare
32 supplement coverage. One copy of the notice signed by the
33 applicant and the agent, except where the coverage is sold
34 without an agent, shall be provided to the applicant and an
35 additional signed copy shall be retained by the issuer as provided
36 in Section 10508. A direct response issuer shall deliver to the
37 applicant at the time of the issuance of the policy the notice
38 regarding replacement of Medicare supplement coverage.

39 (e) The notice required by subdivision (d) for an issuer shall
40 be in the form specified by the commissioner, using, to the extent

1 practicable, a model notice prepared by the National Association
2 of Insurance Commissioners for this purpose. The replacement
3 notice shall be printed in no less than 10-point type in
4 substantially the following form:

5
6 [Insurer's name and address]
7

8 NOTICE TO APPLICANT REGARDING REPLACEMENT
9 OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE
10 ADVANTAGE
11

12 SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE
13 FUTURE.
14

15 If you intend to cancel or terminate existing Medicare
16 supplement or Medicare Advantage insurance and replace it with
17 coverage issued by [company name], please review the new
18 coverage carefully and replace the existing coverage ONLY if
19 the new coverage materially improves your position. DO NOT
20 CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE
21 RECEIVED YOUR NEW POLICY AND ARE SURE THAT
22 YOU WANT TO KEEP IT.

23 If you decide to purchase the new coverage, you will have 30
24 days after you receive the policy to return it to the insurer, for
25 any reason, and receive a refund of your money.

26 If you want to discuss buying Medicare supplement or
27 Medicare Advantage coverage with a trained insurance
28 counselor, call the California Department of Insurance's toll-free
29 telephone number 1-800-927-HELP, and ask how to contact your
30 local Health Insurance Counseling and Advocacy Program
31 (HICAP) office. HICAP is a service provided free of charge by
32 the State of California.

33 STATEMENT TO APPLICANT FROM THE INSURER
34 AND AGENT: I have reviewed your current health insurance
35 coverage. To the best of my knowledge, the replacement of
36 insurance involved in this transaction does not duplicate
37 coverage. In addition, the replacement coverage contains benefits
38 that are clearly and substantially greater than your current
39 benefits for the following reasons:

40 ___ Additional benefits that are: _____

1 ___ No change in benefits, but lower premiums.
2 ___ Fewer benefits and lower premiums.
3 ___ Plan has outpatient prescription drug coverage and applicant
4 is enrolled in Medicare Part D.

5 ___ Disenrollment from a Medicare Advantage plan. Reasons
6 for disenrollment:

7 ___ Other reasons specified here: _____

8
9 DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU
10 HAVE RECEIVED YOUR NEW POLICY AND ARE SURE
11 THAT YOU WANT TO KEEP IT.

12
13
14 _____
15 (Signature of Agent, Broker, or Other Representative)

16
17 _____
18 (Signature of Applicant)

19 _____
20 (Date)

21 (f) No issuer, broker, agent, or other person shall cause an
22 insured to replace a Medicare supplement insurance policy
23 unnecessarily. In recommending replacement of any Medicare
24 supplement insurance, an agent shall make reasonable efforts to
25 determine the appropriateness to the potential insured.

26 (g) ~~An~~ Commencing January 1, 2007, an issuer shall not
27 require or request health information from an applicant who is
28 guaranteed issuance of any Medicare supplement coverage *or*
29 *require or request the applicant to sign a form required by the*
30 *federal Health Insurance Portability and Accountability Act of*
31 *1996. The application form shall include a clear and*
32 *conspicuous statement that the applicant is not required to*
33 *provide health information or to sign a form required by the*
34 *federal Health Insurance Portability and Accountability Act of*
35 *1996 during a period of guaranteed issuance of any Medicare*
36 *supplement coverage and shall inform the applicant of periods of*
37 *guaranteed insurance of Medicare supplement coverage. A*
38 *supplementary application or other form containing those*
39 *statements that the applicant and solicitor are required to sign*
40 *may be used for this purpose. This subdivision shall not prohibit*

1 *an issuer from requiring proof of eligibility for a guaranteed*
2 *issuance of Medicare supplement coverage.*

3 ~~SEC. 29.—~~

4 SEC. 30. Section 10192.20 of the Insurance Code is amended
5 to read:

6 10192.20. (a) An issuer, directly or through its producers,
7 shall do each of the following:

8 (1) Establish marketing procedures to ensure that any
9 comparison of policies by its agents or other producers will be
10 fair and accurate.

11 (2) Establish marketing procedures to ensure that excessive
12 insurance is not sold or issued.

13 (3) Display prominently by type, stamp, or other appropriate
14 means, on the first page of the policy, the following:

15
16 “Notice to buyer: This policy may not cover all of your
17 medical expenses.”

18
19 (4) Inquire and otherwise make every reasonable effort to
20 identify whether a prospective applicant for a Medicare
21 supplement policy already has health insurance and the types and
22 amounts of that insurance.

23 (5) Establish auditable procedures for verifying compliance
24 with this subdivision.

25 (b) In addition to the practices prohibited by this code or any
26 other law, the following acts and practices are prohibited:

27 (1) Twisting, which means knowingly making any misleading
28 representation or incomplete or fraudulent comparison of any
29 insurance policies or insurers for the purpose of inducing or
30 tending to induce, any person to lapse, forfeit, surrender,
31 terminate, retain, pledge, assign, borrow on, or convert an
32 insurance policy or to take out a policy of insurance with another
33 insurer.

34 (2) High pressure tactics, which means employing any method
35 of marketing having the effect of or tending to induce the
36 purchase of insurance through force, fright, threat, whether
37 explicit or implied, or undue pressure to purchase or recommend
38 the purchase of insurance.

39 (3) Cold lead advertising, which means making use directly or
40 indirectly of any method of marketing that fails to disclose in a

1 conspicuous manner that a purpose of the method of marketing is
2 the solicitation of insurance and that contact will be made by an
3 insurance agent or insurance company.

4 (c) The terms “Medicare supplement,” “Medigap,” “Medicare
5 Wrap-Around” and words of similar import shall not be used
6 unless the policy is issued in compliance with this article.

7 (d) The commissioner each year shall prepare a rate guide for
8 Medicare supplement insurance and Medicare supplement
9 contracts. The commissioner each year shall make the rate guide
10 available on or before the date of the fall Medicare annual open
11 enrollment. The rate guide shall include all of the following for
12 each company that sells Medicare supplemental insurance or
13 Medicare supplement contracts in California:

14 (1) A listing of all the policies, plans A to L, inclusive, that are
15 available from the company.

16 (2) A listing of all the policies, plans A to L, inclusive, for
17 Medicare beneficiaries under the age of 65 that are available
18 from the company.

19 (3) The toll-free telephone number of the company that
20 consumers can use to obtain information from the company.

21 (4) Sample rates for each policy listed pursuant to paragraphs
22 (1) and (2). The sample rates shall be for ages 0-65, 65, 70, 75,
23 and 80.

24 (5) The premium rate methodology for each policy listed
25 pursuant to paragraphs (1) and (2). “Premium rate methodology”
26 means attained age, issue age, or community rated.

27 (6) The waiting period for preexisting conditions for each
28 policy listed pursuant to paragraphs (1) and (2).

29 (e) The consumer rate guide prepared pursuant to subdivision
30 (d) shall be distributed using all of the following methods:

31 (1) Through Health Insurance Counseling and Advocacy
32 Program (HICAP) offices.

33 (2) By telephone, using the department’s consumer toll-free
34 telephone number.

35 (3) On the department’s Internet Web site.

36 (4) In addition to the distribution methods described in
37 paragraphs (1) to (3), inclusive, each insurer that markets
38 Medicare supplement insurance or Medicare supplement
39 contracts in this state shall provide on the application form a
40 statement that reads as follows: “A rate guide is available that

1 compares the policies sold by different insurers. You can obtain
2 a copy of this rate guide by calling the Department of Insurance's
3 consumer toll-free telephone number (1-800-927-HELP), by
4 calling the Health Insurance Counseling and Advocacy Program
5 (HICAP) toll-free telephone number (1-800-434-0222), or by
6 accessing the Department of Insurance's Internet Web site
7 (www.insurance.ca.gov)."

8 ~~SEC. 30.—~~

9 *SEC. 31.* Section 10192.21 of the Insurance Code is amended
10 to read:

11 10192.21. (a) In recommending the purchase or replacement
12 of any Medicare supplement policy or certificate, an agent shall
13 make reasonable efforts to determine the appropriateness of a
14 recommended purchase or replacement.

15 (b) Any sale of a Medicare supplement policy or certificate
16 that will provide an individual more than one Medicare
17 supplement policy or certificate is prohibited.

18 (c) An issuer shall not issue a Medicare supplement policy or
19 certificate to an individual enrolled in Medicare Part C unless the
20 effective date of the coverage is after the termination date of the
21 individual's coverage under Medicare Part C.

22 ~~SEC. 31.—~~

23 *SEC. 32.* No reimbursement is required by this act pursuant to
24 Section 6 of Article XIII B of the California Constitution because
25 the only costs that may be incurred by a local agency or school
26 district will be incurred because this act creates a new crime or
27 infraction, eliminates a crime or infraction, or changes the
28 penalty for a crime or infraction, within the meaning of Section
29 17556 of the Government Code, or changes the definition of a
30 crime within the meaning of Section 6 of Article XIII B of the
31 California Constitution.